Practical Guidance

# Insurance M&A Transactions

**A Practical Guidance® Practice Note by**
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## Introduction

This practice note explores some central aspects of successfully structuring, negotiating, and documenting an insurance M&A transaction. It also addresses considerations that are specific to, or assume more importance in, M&A transactions in the insurance industry. Such considerations affect nearly every stage of the M&A process, including structuring the deal, due diligence, negotiating the terms of the purchase and sale agreement, and addressing post-closing matters.

Although the structure and terms of insurance M&A transactions vary, the following factors affect all insurance M&A deals:

- The insurance business model, which is based on the management of potentially large and unpredictable liabilities and correlated assets requiring prudent risk management strategies
- State regulatory regimes, in which active regulators play a central role
- An industry standard financial reporting system that is focused on a company's liquidation value rather than the going concern value of the company
- A highly specialized, capital-intensive, and seasoned industry with high barriers to entry – and –
- An industry that has developed over many centuries with its own terminology and particularities, which can be difficult for outsiders to penetrate

While this article will discuss various ways in which insurance M&A transactions can be structured, it will focus on the due diligence and negotiation issues in a "classic" insurance M&A transaction—namely, the acquisition by an acquirer from a seller of all of the common stock of a stock insurance company.

## The Insurance Business

Generally speaking, insurance is a mechanism for contractually shifting the burden of a number of pure risks by pooling those risks. A pure risk involves the chance of a loss or no loss (but no chance of a gain). The purchaser of an insurance contract must be subject to a pure risk of incurring an economic loss (i.e., must have an insurable

interest). This concept is central for determining whether the product in question is in fact an insurance product rather than, for example, an option or a gambling product.

There are two key aspects of an insurance company's business model: underwriting and asset management. An insurer's underwriting business consists of issuing policies to policyholders, collecting premiums on the policies, and paying claims to policyholders who suffer losses covered by the policies. The underwriting business will be profitable if the insurer collects more in premiums than it pays out in claims. Simply looking at the success or failure of an insurer's underwriting business, however, does not tell the whole story of an insurer's profitability. The insurer's ability to generate investment income on the premiums held by the insurer (i.e., its asset management business) is also of importance. For example, an insurer that collects all of its premiums on January 1, and returns every penny of those premiums to policyholders on December 31, may still be very profitable if it earns investment income on those premiums. This is why some commentators suggest that issuing insurance is merely a pretext for gathering assets under management and that insurers are, more than anything, asset managers. Regardless of how one views the essence of the insurance business, it is clear that both underwriting and asset management are crucial elements. This dual nature of the insurance business model permeates an insurer's organization and activities.

The insurance industry is divided into two main segments:

- Life, annuity, and health
- Property and casualty

The insurance products written in the life segment are typically of long duration, with potential payment obligations lasting many years. Life insurance companies must carefully balance asset yields with these long durations of liability to ensure payments can be made when required. To do this, successful estimation of the length and peak of long-term liabilities is critical.

Property and casualty insurers usually write insurance of considerably shorter duration. Other than for certain types of casualty insurance, such as environmental and asbestos insurance, property and casualty insurance is typically written yearly. Rather than calculating the potential duration of the insurance liability, property and casualty companies manage instant and catastrophic risk through various risk management strategies, like spreading the risk across many actors, such as reinsurers, who essentially insure the insurer, or diversifying the risk profile.

Many property and casualty insurers and reinsurers are domiciled in Bermuda, thanks to its favorable tax regime, less onerous regulatory rules, and growing pool of insurance experts. Bermuda-domiciled property and casualty insurers and reinsurers are often considered part of the U.S. market, due to Bermuda's geographic proximity to the U.S. and its ability to efficiently serve and support the U.S. insurance and reinsurance market.

## The Regulatory Regime

With the McCarran–Ferguson Act of 1945, the U.S. Congress ensured that the primary responsibility for insurance regulation would remain with the states. Each state has adopted its own insurance legislation and established an insurance regulatory body tasked with promulgating state-specific regulations and guidelines, monitoring insurers and their operations, and intervening in their operations when necessary. As a result, the legal framework for an insurance company will depend primarily on where it is organized or domiciled and secondarily on where it is operating. State insurance laws regulate insurance companies that are domiciled in that state more extensively than those merely conducting business in the state. The policy rationale for this is that insurer stakeholders (such as policyholders, employees, and business partners) who are located in the domiciliary state are more likely to be affected by the insurer's insolvency as well as its market conduct and other activities. Some states (California, Florida, and Texas are notable examples) will deem an out-of-state insurer to be "commercially domiciled" in the state if the insurer meets certain thresholds for business activity in the state (typically based on a percentage of business written in that state over the course of the most recent three years).

Another important aspect of the state-based system of insurance regulation is that federal bankruptcy laws generally do not apply to insurers. In the event of an insurance company's actual or threatened insolvency, the insurance regulator of the domiciliary state has far-reaching powers to intervene in the insurer's operations, including the power to seize control of the insurer. Drafting and negotiating contract provisions addressing an insurance company's insolvency, or proximity to insolvency, should be viewed in that light. For example, contract provisions dealing with actions to be taken by an insurer may not be enforceable if the insurer is deemed to have financial difficulties and the regulator has determined it is necessary to intervene.

Although the main features of the legal framework for the insurance industry are state-specific, there have been efforts to harmonize insurance laws across state borders. The most prominent forum for these efforts is the National

Association of Insurance Commissioners (NAIC). The NAIC is a standard-setting and regulatory support organization created and governed by the head insurance regulators of the 50 states, the District of Columbia, and the five U.S. territories. The NAIC's objective is to represent the collective views of U.S. state insurance regulators. Through the NAIC, regulators establish standards and determine best practices, conduct peer review, and collaborate on regulatory oversight. The NAIC also creates model laws, which are typically adopted into the states' legal frameworks in some form. The NAIC has effectively harmonized many state insurance laws across the United States. This is particularly true in the area of financial reporting, where the NAIC has adopted forms for insurers' annual and quarterly financial statements (known as statutory statements), statutory accounting principles, a financial examiners' handbook, and procedures for valuation of securities. All of these tools are used throughout the U.S. insurance industry.

The insurance industry is also subject to various federal laws with both indirect and direct application, including:

- The Gramm–Leach–Bliley Act of 1999, which impelled the states to establish a more uniform, reciprocal system for producer licensing
- The National Association of Registered Agents and Brokers Reform Act of 2015, which provided for the establishment of a national clearinghouse to streamline market access for nonresident insurance producers
- The Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (Dodd-Frank), which established a federal insurance office to serve as an information resource for the U.S. Congress and the industry, and which gave the U.S. Department of the Treasury the power to designate insurance companies as systemically important financial institutions (SIFIs), resulting in a framework for heightened regulatory oversight (the first financial institutions that were not traditional banks given this designation were AIG, Prudential Financial, GE Capital, and MetLife, but all four have since managed to shed their SIFI designations, effectively causing this federal oversight tool for the very largest insurance companies to go dormant for the time being)
- The Nonadmitted and Reinsurance Reform Act of 2010 (enacted as part of Dodd-Frank), which streamlined access to the nonadmitted insurance market for large commercial purchasers of insurance and limited the authority of non-domiciliary states to regulate reinsurance transactions

Dodd-Frank also authorizes the Office of the United States Trade Representative and the Secretary of the Treasury to enter into bilateral or multilateral "covered agreements" with foreign jurisdictions to address regulatory reciprocity with respect to insurance and reinsurance operations. Such covered agreements can under certain circumstances preempt state laws if the laws are less favorable to non-U.S. insurers or reinsurers than to U.S. based companies. The recent covered agreements on the topic of reinsurance that have been entered into by the U.S. with the European Union (EU) and the U.K. have therefore spurred NAIC and state legislative activity in order to conform state laws to the covered agreements.

## Insurance Holding Company System Model Act and Regulation

The NAIC recognized early on that there was a need to supervise the businesses and operations of insurance companies not only in isolation but also in relation to their affiliated companies. An insurance company that is ultimately owned by legal or natural persons with low creditworthiness or with a history of fraudulent or otherwise questionable transactions may put the insurer at risk. Likewise, a transaction between an insurance company and a non-insurer affiliate that favors the non-insurer to the detriment of the insurance company may put the insurance company and its policyholders at risk. To address some of these issues, NAIC adopted in 1961 a model act and accompanying regulations known as the Insurance Holding Company System Regulatory Act and Insurance Holding Company System Model Regulation with Reporting Forms and Instructions.

Although changes have been made to the model act and related regulations since 1961, the approach to group supervision has been cemented at both the NAIC and state levels. Thus, the model act and regulations, as adopted in a state, give the state regulator a say over relationships and transactions involving an insurance group that could be harmful to the insurance companies within the group. The model act and regulations are based on a filing system wherein the insurance company discloses pending or completed business activities to the state regulator. The following filings are required under most state insurance holding company system regimes:

*Form A: Statement Regarding the Acquisition of Control or Merger with a Domestic Insurer.* A person who desires to acquire control of a U.S. insurer is required to file a change of control statement, known as a Form A, with the domiciliary regulator. "Control" is presumed to be acquired

when, as a result of an acquisition, a person holds, directly or indirectly, 10% or more of the voting securities of the insurer. This presumption can be rebutted if the acquirer files a disclaimer of control explaining, essentially, why the acquirer should be viewed as a passive investor. The domiciliary regulator must approve the Form A filing before the transaction is allowed to be consummated. The regulator will review the terms of the transaction, the appropriateness of the acquirer, and the acquirer's business plan (including financial projections). Biographical affidavits (and, in some states, fingerprints) of directors and officers of the acquirer and persons proposed to become directors and officers of the target will be required as part of the Form A filing. The regulator will sometimes request that a public hearing be held prior to approving or rejecting the Form A. In some states, public hearings are mandatory.

The main criterion for regulatory approval of a Form A application is whether the proposed acquisition would be consistent with the best interests of the target insurer's policyholders. Among other things, examiners who review Form A applications are required to consider the following:

- All aspects of the financial condition of the acquiring entity, including the acquiring group's business model, general business strategy, and specific strategy with respect to the acquired insurer
- The risks of the acquiring entity and its group, including credit, market, pricing, underwriting, reserving, liquidity, operational, legal, strategic, and reputational risk and, in particular, risks associated with the acquirer's investment strategies
- Whether specific additional requirements should be imposed on the acquirer as a condition for approval, such as: (i) maintaining a risk-based capital (RBC) ratio for the target insurance company at a higher level than normally required (for a discussion of RBC, see Risk-Based Capital); (ii) submitting RBC reports quarterly, rather than annually; (iii) obtaining regulatory approval for dividends during a certain period of time; (iv) establishing a capital maintenance agreement or prefunded trust account to secure policy claim payment obligations; (v) disclosing direct and indirect controlling equityholders of the acquirer; or (vi) requiring personal financial statements from all controlling persons of the insurer – and –
- Whether certain post-closing measures should be imposed, such as an annual stress test of the target insurance company or targeted examinations to ensure that the proposed investment strategy is followed and continues to be sound

*Form B: Insurance Holding Company System Annual Registration Statement and Form C: Summary of Changes to Registration Statement*. All domestic insurers that are members of a holding company system must register with the applicable state regulator. Any insurer required to register must do so within 15 days after it becomes subject to registration and, annually thereafter, must submit an amended registration statement for the previous calendar year. The annual holding company registration statements, commonly referred to as Forms B and C, must be filed on forms provided by the relevant state regulator.

*Form D: Prior Notice of a Transaction*. Form D filings may be applicable in the M&A context, but are conceptually unrelated to change of control transactions. Form D is used to disclose transactions between an insurance company and one or more of its affiliates. Because insurance regulators are wary of contractual terms that appear to favor a non-insurer affiliate to the detriment of an insurer affiliate (e.g., an excessive investment management fee payable by the insurer to an affiliated investment management arm of the group), regulators want to review the terms of affiliate transactions before such arrangements are implemented. The insurer must file a Form D with its domiciliary regulator and include the proposed affiliate agreement at least 30 days prior to the expected execution date. If the regulator does not object to the terms of the agreement within the 30-day period, the agreement is deemed approved.

In connection with the acquisition of an insurance company, it is not uncommon for the parties to agree to distribute the target company's surplus capital to the seller immediately prior to closing. Dividends or distributions that exceed a specified threshold when added to dividends paid over a rolling 12-month period (i.e., "extraordinary dividends") are subject to the Form D or similar non-disapproval filing process. Ordinary dividends are typically not subject to approval, but must be reported to the domiciliary insurance department within a stipulated period after declaration and before payment of the dividend.

*Form E: Pre-Acquisition Notification Form*. Form E filings are required in many states to allow the state insurance regulator to determine whether an acquisition of an insurer may have anti-competitive effects on the insurance market in the state. In states that require Form E filings, subject to certain exemptions for acquisitions that will affect the market in a state only minimally, a Form E pre-notification filing will need to be made if any of the insurers involved in the transaction are licensed (not just domiciled) in the state. Regardless of whether any Form E filing is required, a federal Hart–Scott–Rodino filing and waiting period may still apply to the transaction.

*Form F: Enterprise Risk Report*. Form F filings are a relatively new creation that principally came about as a reaction to

AIG's near failure in September 2008 and subsequent rescue by the Federal Reserve and U.S. Treasury. Form F filings must be made with the domiciliary regulator to identify systemic enterprise risk within the holding company structure. The Form F procedure requires the ultimate controlling person of the group to submit an annual enterprise risk report, in which the enterprise risks are identified. Enterprise risk is defined as "any activity, circumstance, event or series of events involving one or more affiliates of an insurer that, if not remedied properly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company as a whole" (see Insurance Holding Company System Regulatory Act §1H (1st Quarter 2015)).

As noted above, several of these filings (and related approvals) may be required in connection with an M&A insurance transaction. Note also that if an insurer is deemed to be commercially domiciled in a state that applies holding company regulation to commercially domiciled insurers (see The Regulatory Regime), the insurer and the acquirer may also be required to make filings in that state.

## Government Ownership Statutes

Statutes in more than half of the U.S. states impose restrictions on government ownership or control of insurance companies licensed to do business in the state. If an acquirer is owned or controlled, directly or indirectly, in whole or in part, by a U.S. or foreign government or government agency, the impact of those statutes will need to be considered. Among other things, such statutes may restrict the ability of the insurer to claim sovereign immunity based on its governmental ownership or to receive subsidies from a governmental parent.

## GAAP Versus SAP

Most U.S. companies use generally accepted accounting principles (GAAP) to report their financial information. While GAAP is officially recognized as authoritative by the Securities and Exchange Commission (the SEC) and the American Institute of Certified Public Accountants, in the U.S. insurance industry, GAAP accounting is secondary. State regulations require insurance companies to report financial information using Statutory Accounting Principles (SAP). SAP is a uniform framework developed by the NAIC, principally to ensure that state regulators have the right tools to assess the condition and performance of the insurance companies they monitor and to evaluate their solvency. Unlike GAAP accounting, which assumes an entity will continue to operate following the date of determination, SAP aims to determine what assets would be available to discharge the entity's liabilities if the entity were liquidated "today." For example, SAP does not allow an insurer to include certain non-liquid and intangible assets on the balance sheet (e.g., goodwill, supplies, furniture, and certain tax credits can be included as assets on a balance sheet prepared in accordance with GAAP, but are generally excluded as "non-admitted assets" under SAP). The main purpose of the conservative approach adopted by NAIC and state regulators through SAP is to ensure that each insurance company can meet its obligations to policyholders at any given moment.

## Risk-Based Capital (RBC)

Insurance regulators use RBC to measure the minimum amount of capital appropriate for an insurer to support its overall business operations, taking into account its size and risk profile. The RBC calculation focuses on the amount of risk an insurer can take on, and requires an insurer with a higher risk profile to hold a higher amount of high-quality capital. Risk factors used to determine the RBC formula are separated into three main categories: asset risk, underwriting risk, and other risks (e.g., credit and counterparty risk). The emphasis placed on these risks will differ from one type of insurance company to another. For example, holding equity investments is less risky for a life insurance company with longer-term liabilities than it is for a casualty and property company with more immediate payment obligations.

The regulatory utility of RBC is addressed by the NAIC on its website as follows: "RBC is intended to be a minimum regulatory capital standard and not necessarily the full amount of capital that an insurer would want to hold to meet its safety and competitive objectives. In addition, RBC is not designed to be used as a stand-alone tool in determining financial solvency of an insurance company; rather it is one of the tools that give regulators legal authority to take control of an insurance company" (see http://www.naic.org/cipr_topics/topic_risk_based_capital.htm). Accordingly, the RBC metric is one of many tools, albeit probably the most important, used by regulators to determine whether regulatory intervention is warranted. For instance, an RBC ratio below 200% indicates that the insurer has financial difficulties. Under such circumstances, the regulator may request that the insurer submit a plan for improvement of its capital position. If the RBC ratio drops below 100%, the regulator may take control of the insurer.

# Deal Structure Considerations

M&A transactions in the insurance sector can take many forms. The structure is dictated by the parties' motivations for the transaction and factors such as timing, certainty of consummation, and the regulatory framework in which the transaction occurs. The following are some of the most common structures for insurance M&A transactions.

## Acquisition of Insurance Entity

Counsel to the acquirer needs to understand what kind of insurance entity is being acquired, as different types of entities bring different deal considerations.

### *Stock Insurance Companies*

Most insurance companies are stock companies owned by the holders of the insurance companies' capital stock. In contrast to a mutual insurance company, the profits of a stock insurance company accrue for the benefit of the shareholders rather than the policyholders. However, the distribution of any profits generated is subject to regulatory restrictions and, in some cases, approval by the domiciliary regulator. Regulators are tasked with protecting the interests of policyholders and ensuring that the insurance company maintains sufficient capital and surplus to cover current and future claims. As such, regulators view restrictions on dividends and distributions as an important tool to protect the long-term viability of the insurance company and its ability to pay future policyholder claims.

Counsel should be aware that regulatory restrictions on dividends may prevent the parties from causing the target company to distribute excess cash before, or even after, consummating an M&A transaction. For example, New York generally requires an insurer to agree not to pay any dividends without regulatory approval for a period of three years after a change of control. Depending on how the purchase price for the target company is determined, this may mean that the acquirer will have to "pay" for restricted capital held by the target company. As such, the acquirer's financial models should account for the fact that what the parties perceive to be excess capital may not be distributable at the time the acquisition is consummated. However, it will often be possible to assess through private discussions with the regulator what capital and surplus levels will be required upon consummation of the transaction. In any event, the acquirer and seller are wise to address, in the purchase agreement, how restricted capital is to be treated in the transaction.

### *Mutual Insurance Companies*

Mutual insurance companies, or "mutuals," are collectives of insureds pooling their risk for the common good of the collective. Mutuals do not have stockholders. Instead, they are owned by their members (i.e., the policyholders of the insurance company). Membership interests in a mutual are not transferable separate and apart from the underlying policy, and a membership interest ends when the policy ends. In contrast to a stock insurance company, the profits of a mutual insurance company accrue for the benefit of the policyholders (since there are no stockholders). There are many large mutuals in the insurance industry, such as State Farm, Nationwide, and Guardian Life.

Since a mutual insurance company has no stockholders, it cannot be acquired in the usual sense of the word. Therefore, prior to the acquisition of a mutual insurer, it must be converted into a stock company in a process known as demutualization. Demutualization can extend for months or even years, involving discussions with state insurance regulators, one or more public hearings, and an affirmative vote by the policyholders. Depending on the mutual's domiciliary state, the required affirmative vote can range from a simple majority to a supermajority of the policyholders. The insurance laws of some states restrict acquisition of more than a certain percentage of the voting rights in the company for a period of time prior to and following demutualization. However, such restrictions can typically be waived by the domiciliary regulator. In a demutualization occurring for the purpose of a later sale, also known as a sponsored demutualization, it is important for the acquirer and the board to vet the proposed acquisition with regulators, key policyholder groups, and other stakeholders to avoid unforeseen and costly hurdles.

### *Licensed Shell Company*

A licensed shell company is a dormant insurance company that holds one or more insurance licenses. In other industries, a dormant entity would likely be liquidated and dissolved once it becomes non-operative. In the insurance industry, a dormant shell company could have an intrinsic value because of the licenses it holds.

Each state has its own requirements for granting out-of-state insurance companies a license to transact business in its state. Subject to certain exceptions, most states require an out-of-state insurer to have been organized and actively engaged in insurance business in its domiciliary state for a certain period of time prior to being granted a license in the other state. For example, New York, California, and Florida require prior operation of at least three years. Considering the process required to incorporate and license a new insurance company in its domiciliary state, which

can range from a couple of months to more than a year, acquiring a licensed shell company can be an attractive option for an acquirer looking to start new operations or expand current operations. Because the acquirer of a shell company expects to acquire a company without net liabilities, it is common for the acquirer to request that the seller assume all pre-closing liabilities of the shell company. This approach is similar to an asset sale, where the seller retains certain pre-closing liabilities related to the assets. Limitations on indemnification in shell company transactions can sometimes be a contentious negotiating point for the parties. The seller will not want to be responsible for more than the (usually) modest purchase price it receives. The acquirer will view any problem associated with the shell company as antithetical to the very purpose of acquiring a "clean" shell and therefore will want to remove limitations on indemnification.

### *Reciprocal*

A reciprocal, otherwise known as an interinsurance exchange, has no corporate existence, but is rather a network of policyholders who insure, and are insured by, each other. The actual administration of the network (e.g., policy issuance and claims handling) is managed by an attorney-in-fact—either a legal entity or an individual. In the case of a reciprocal, what is acquired is not the network itself, but the attorney-in-fact (if a legal entity) and the stream of fees received by the attorney-in-fact for managing the reciprocal.

## SPACs and "De-SPACing" Transactions

Special purpose acquisition vehicles (SPACs) or "blank check companies" are not specific to the insurance industry and are not a particularly new phenomenon, but they have recently experienced renewed popularity in the M&A market (in 2020, according to *SPACInsider*, a trade publication, 248 SPACs completed their initial public offerings (IPOs), raising over $83 billion). SPACs are newly formed companies that raise equity in an IPO for the stated business purpose of completing a business combination with another entity by using the proceeds raised in the IPO, the proceeds of further capital raises, or common stock. The proceeds of the IPO (less the underwriting discount paid in the IPO) are placed in a trust fund that can only be used to consummate a business combination or, if a business combination is not completed within a specified period of time (typically 18–24 months), to redeem the public shareholders. If the SPAC completes its initial business combination (often referred to as a "de-SPACing" transaction), the target operating company is the surviving public company. Thus, one of the key drivers for a target operating company to undergo a business combination with a SPAC is to essentially accomplish an IPO through a merger.

The SPAC's business plan often specifies a particular industry or geographic focus for its search of a target company. In 2020, three SPACs completed IPOs with a stated focus on the insurance (including insurtech) market. While combining with a SPAC can be a faster route to become a public company than the traditional IPO path, insurance companies should be aware of the possibility that a Form A approval (see Insurance Holding Company System Model Act and Regulation) may be required in a de-SPACing transaction. Such approval could delay consummation of the deal, and even force a shareholder vote to approve an extension to the time period mandated by the SPAC to consummate a transaction. Parties pursuing a de-SPACing transaction with an insurance company target are therefore well advised to consult with insurance regulatory counsel to ascertain whether or not a Form A approval is required.

## Acquisition of a Block of Business

If the presumptive acquirer is not interested in using the target insurance entity as a vehicle to write new business—or is solely interested in part of the target entity's written business and is not seeking to assume employee, operational, and other liabilities not related to insurance—it may seek to "acquire" a specified block or portfolio of insurance policies. Block and portfolio acquisitions can take various forms.

### *Indemnity Reinsurance*

A common way to acquire a portfolio or block of business is to reinsure the insurance policies written by an insurer. This is often called "bulk reinsurance." Reinsurance is a contract by which the reinsurer assumes the risks of another insurer (the cedent), who transfers or cedes the risk to the reinsurer. The cedent passes to the reinsurer all or part of the premiums it receives from the relevant policyholders, subject to a ceding commission payable by the reinsurer to the cedent, which is intended to cover expenses the cedent incurs in finding and writing the business. If the profitability of the block of business is questionable, the commission could go in the opposite direction, from the cedent to the reinsurer. The typical reinsurance contract is not a liability contract but an indemnity contract. This means that the cedent is still the contractual party to the underlying insurance policy issued to the policyholder and therefore remains the contractual party liable to the policyholder. The role of the reinsurer is to indemnify the cedent after the cedent has paid a loss

on the underlying policy to the policyholder. Typically, the reinsurance contract will stipulate that the cedent will cover only the risk associated with the reinsured block of business and not more; although in some negotiated reinsurance arrangements, the reinsurer may also cover ex gratia (i.e., from a moral, not legal obligation) payments, "bad faith" penalties, and other extra-contractual liabilities that the cedent did not expressly assume pursuant to the terms of the policy with the insured, but that it may nevertheless have to pay as a consequence of, for example, deficient adjustment practices of policyholder claims.

Through a reinsurance agreement under which all premiums and liabilities associated with a cedent's block of business are transferred to the reinsurer (known as a 100% quota share indemnity reinsurance agreement), the reinsurer will in effect acquire all of the revenue streams and liabilities associated with that block of business. A reinsurance transaction could also involve one or more subsequent acquisitions of the same block of business by a second-in-line reinsurer (a retrocessionaire), who would reinsure all or part of the risk assumed by the original reinsurer (the retrocedent).

### *Assumption Reinsurance*

If the intended reinsurer wants to step into the shoes of the insurer for a particular block of business, rather than reinsuring the block, the parties can effect an assumption reinsurance transaction. The term is in fact a misnomer, since the arrangement is not really a reinsurance transaction but rather a novation arrangement. In an assumption reinsurance transaction, the acquirer substitutes itself in place of the original insurer as the contracting party under the insurance contracts with the policyholder by novating the contracts, thereby entering into a direct contractual relationship with the policyholders. It is typically required that the policyholders consent to the novation, either by signing a written consent or by paying future premiums to the acquirer. From the perspective of the original insurer, the objective of express or tacit consent from the policyholder is to establish evidence of a clean break from the liabilities associated with the policies being novated. Assumption reinsurance transactions are relatively uncommon because of the difficulty in obtaining consent from a large number of policyholders.

### *Renewal Rights Transaction*

In a renewal rights transaction, the acquirer purchases from the seller the exclusive right to use the existing business relationships with policyholders to seek to write any renewals of policies on the acquirer's paper. A renewal rights transaction may serve as a useful complement to an acquisition of a block of business through reinsurance, as those two elements would both secure the economics of the existing business and allow the reinsurer to directly acquire any future insurance written from such block of business. Renewal rights transactions present some unique challenges. Depending on the overall nature of the transaction, the seller may be prevented by consumer privacy and data protection rules from sharing information about the policyholders. This is particularly likely before the transaction closes and during due diligence. Moreover, agents and producers who brokered the original sale of the insurance contracts to the policyholders may have rights to policyholder information that may limit the ability of the insurer to pass that information on to the acquirer. Finally, any transaction involving direct action by policyholders to consent to a novation or a renewal of policy with a new insurer is likely to result in some attrition. One way to address this potential predicament is to make all or part of the consideration for the renewal rights contingent on the number of policies that are actually renewed.

## Insurance Business Transfer Legislation

Some states have acknowledged that the difficulty of obtaining policyholder consent for an assumption reinsurance or renewal rights transaction may prevent transactions from occurring that are otherwise sound and in the interest of both policyholders and insurers. Accordingly, in recent years there has been an upswing in states' adoption of legislation that allow for the transfer and novation of a block of insurance business without the need to seek policyholder consent (where it otherwise would have been required). For instance, Oklahoma, Rhode Island, and Vermont have enacted legislation, generally known as insurance business transfer laws, which take policyholder consent out of the picture and instead provide for a process whereby the domiciliary regulators of the transferee and transferor approve (or do not object) to the transfer, and subsequently allow the parties to have the district court of the transferee endorse the transfer. While the Oklahoma, Rhode Island, and Vermont insurance business transfer laws have certain distinct features, the general process of the laws consist of the transferring insurer submitting a plan, outlining the transfer, to the transferee's domiciliary regulator for approval (which must also be blessed by the transferor's domiciliary regulator). The regulators consider if the plan is viable and, in particular, whether the transfer would have a material adverse impact on policyholders or claimants (and, in some cases, the reinsureds). Following receipt of the required approvals, the domiciliary regulator of the transferee will grant the parties the right to apply to the district court for approval of the plan. The court must hold a public hearing in connection

with the approval process, and if approved, the parties are permitted to consummate the transfer. In October 2020, the Oklahoma County District Court approved the insurance business transfer plan filed by Providence Washington Insurance Company, the transferring insurer, and Yosemite Insurance Company, the assuming insurer, making it the first transfer approved under an insurance business transfer law in the U.S. and paving the way for future similar transactions.

### *Pension Liability De-risking Transactions*

One type of transaction that gained popularity a few years ago involves the "de-risking" of pension liabilities of large corporations. In these transactions, corporations with large defined benefit pension plans enter into a group annuity contract with a life insurance company. The group annuity contract is designed to cover all future payments to be made under the plan by substituting payments by the life insurance company under the group annuity contract for the payments that would otherwise be due from the pension plan. The group annuity contract is purchased by the corporation using the plan assets and, in some cases, additional cash (e.g., if the plan is deemed underfunded). Following the purchase of the group annuity contract, the corporation is relieved of all responsibility for future payments to participants covered by the group annuity contract. These transactions are sometimes combined with a buy-out feature. In those cases, participants that are currently receiving payments under the pension plan may be offered an opportunity to receive a lump-sum payment instead of continued payments under the group annuity contract. Several large corporations with large pension liabilities have undergone these types of de-risking transactions, including General Motors (transaction value of $26 billion), Ford (potentially $18 billion), Verizon ($7.5 billion), Bristol-Myers Squibb ($5.2 billion over the course of two separate transactions), and Motorola ($3.1 billion).

A defined benefit plan may be viewed as a "quasi" life insurer that provides lifetime annuities to plan participants. In this light, a pension de-risking transaction involving the transfer of liabilities to a "real" life insurer (through the purchase of a group annuity contract) resembles an M&A transaction involving the sale of an annuity book from one insurer to another. Consequently, the large de-risking transactions to date have generally followed a process similar to a privately negotiated M&A deal.

So far, these transactions have held up under legal scrutiny by the courts. In April 2014, a federal court in Texas dismissed for the third time a class action suit challenging Verizon's de-risking transaction on the grounds of various ERISA violations, including deficient disclosure and breaches of fiduciary and anti-discrimination obligations. Among other things, the court noted that ERISA permits an employer to make business decisions in its "settlor capacity." The court held that the decision to pursue a particular de-risking settlement strategy, including the right to transfer assets and liabilities to an insurance company, is a business decision that a plan sponsor is permitted to make under ERISA. In August 2015, the district court's decision was affirmed by the U.S. Court of Appeals for the Fifth Circuit.

Certain attempts at legislative action have been made. In 2015 Connecticut enacted legislation to provide protection from creditors to payments to participants or beneficiaries under an annuity purchased to fund employee or retiree retirement benefits. CONN. GEN. STAT. § 52-321a. In New York, state legislators have explored the possibility of legislation addressing de-risking transactions; the most current bill was introduced in 2021. 2021 Legis. Bill Hist. NY A.B. 6099. Some commentators argue, however, that legislative changes in state assemblies that conflict with ERISA would be fruitless because of federal law preemption. A group of state insurance legislators called the National Conference of Insurance Legislators (NCOIL) prepared a model act for de-risking transactions. NCOIL's proposal received lukewarm reception from the industry and did not move forward in any tangible way. NCOIL then turned to developing best practices for the industry in collaboration with market participants. In November 2014, NCOIL adopted the following best practices:

- State guaranty associations should provide a minimum guaranteed level of coverage of no less than $250,000. Guaranty associations require mandatory insurance company membership and are designed to protect policyholders from an insurance company that has become insolvent and is no longer able to meet its policy obligations
- Payments to individuals should be protected from creditors, comparable to the protection granted to pension payments under ERISA (note that in October 2015, legislation went into effect in Connecticut that affords the same protection from creditors that pension payments enjoy under ERISA to payments under a group annuity that replace pension payments)
- Individuals should be provided with clear information about the key elements of their group annuity arrangement – and –
- States should adopt laws to protect annuity transfers to insurance companies that do not have sufficient financial strength to guarantee that payment obligations will be met

The de-risking transactions that have taken place so far appear to be beneficial to corporations that desire to

manage their long-term pension obligations predictably and for life insurance companies that manage long-term risk. Importantly, there appears so far to be no compelling evidence to support the notion that payments received under a group annuity contract from a creditworthy life insurer pose more risk to plan participants than pension payments received under a corporation's defined benefit pension plan.

# Due Diligence in Insurance M&A Transactions

As with any M&A transaction, careful due diligence is an important element of a successful acquisition of a target insurance company. Naturally, many of the matters covered during due diligence of an insurance company are the same as those covered in other types of M&A transactions, such as pending and threatened litigation, owned and leased real property, tax matters, labor and benefits matters, and environmental liabilities. Nevertheless, there are several aspects of the due diligence process that are unique to or particularly important in the acquisition of an insurance company. These include:

- Calculation and adequacy of reserves
- Underwriting and claims administration
- Market conduct and producers
- Regulatory matters, including licensing issues, permitted practices, regulatory filings, and interactions with government agencies
- Collectability of reinsurance
- Composition of the investment portfolio
- Dependency on intercompany agreements
- Data security and compliance with privacy laws – and –
- Other financial arrangements, including reserve financing

Once the acquirer's counsel has a full understanding of these matters, it will be possible to advise the acquirer on the legal issues raised by the transaction and assist in creating a suitable structure. In addition, once the initial due diligence is completed, acquirer's counsel will be better equipped to stress test the due diligence findings through a carefully drafted catalog of seller representations and warranties. As noted in the Introduction, the following discussion assumes the outright acquisition of a stock insurance company.

## Calculation and Adequacy of Reserves

If an insurer's products are priced correctly, the average loss on a portfolio of policies should be covered by the premiums received. Being correct about the average, however, does not protect the insurer from temporary and extraordinary payment obligations outside the average, or payment obligations that arise earlier than the receipt of sufficient premiums to honor such obligations. It is also quite possible for insurers to price products incorrectly. For all of these reasons, insurance companies maintain reserves to cover their current and future liabilities. Inadequate reserving can have a devastating impact on an insurer, which is why due diligence efforts by the acquirer should focus on the manner in which reserves have been calculated and the assumptions underlying the calculation. The acquirer may also retain outside actuaries to conduct an independent review of the reserve assumptions and calculations. At the very least, the acquirer will want to review any internal or third-party actuarial studies performed on the target insurer's reserves and reserve practices.

## Underwriting and Claims Administration

An important measure of an insurer's financial performance is its loss ratio. The loss ratio is the ratio of incurred losses plus loss adjustment expenses to earned premium, without regard to the performance of the insurer's investment assets. The higher the insurer's loss ratio, the less money it is making on its underwriting business. If the loss ratio is more than 100%, the insurer is losing money on its underwriting business (which can be partially or wholly offset by positive returns on its investment portfolio). Deficient or lax underwriting practices can easily lead to a high loss ratio. Therefore, it is important for the acquirer to assess the insurer's underwriting practices (e.g., quality of procedures, level of discipline in following those procedures, and quality of the technological tools available) to make sure that the risks assumed are appropriate. It will also be important for the acquirer to understand how claims are handled. Claims administration and loss adjustment practices that are prolonged or flawed can result in higher costs and claim payouts as well as policyholder lawsuits and regulatory scrutiny. If the target has been adjudged to have paid less than provided for by a policy (without good reason), the target could be held liable for "bad faith" penalties or extra-contractual obligations in excess of the stated insurance coverage. If these issues are severe, the target's licenses and right to operate could be put in jeopardy.

## Market Conduct and Producers

Another aspect of the target's operations that the acquirer will want to investigate is the manner in which the target conducts its business in the marketplace. Is the target in compliance with insurance marketing rules in the way it advertises and discloses information about its products?

Has the target filed all its policy forms and rates with applicable regulators, and have such forms and rates been approved (or non-disapproved within the period mandated for regulatory response) by the relevant authority? Most insurance companies also engage agents, brokers, and other producers to sell their insurance products. The acquirer will want to know whether such producers have authority to contractually bind the target. Although delegating such authority to third-party producers could provide for a more efficient sales procedure, the target gives up some of its control and ability to ensure adherence to its underwriting policies and sales procedures. The acquirer will also want to assess whether unlicensed persons are being compensated for referring business to the target. For instance, a party without a producer license referring business to the target and being compensated for such referrals through a commission structure could be in violation of state licensing rules. Large insurance companies generally use third-party producers to market and sell their insurance products, and it can be difficult to monitor such producers' behavior and their compliance with laws and regulations. Reviewing the target's standard terms of agreement with producers and receiving a list of the producers generating the largest revenues can be a good place to start during the diligence process. Insurers are also subject to routine market conduct examinations by state regulators, and the findings from these examinations will provide useful information to the acquirer.

## Regulatory Matters

The acquirer's counsel is particularly involved in regulatory due diligence. As part of the regulatory due diligence, counsel will want to review and consider the following:

- *Certificates of authority*. Counsel should determine whether all of the target's certificates of authority (i.e., insurance licenses) and the specific lines of business listed on such certificates are current and in effect. Counsel should also consider if the certificates are conditioned upon operational restrictions or capital maintenance obligations. A review of the certificates in conjunction with the statutory statements will also confirm that there is a certificate of authority for each jurisdiction in which the insurer reported premiums.
- *Commercial domicile*. The due diligence examination should determine whether the target is commercially domiciled in any jurisdiction. See The Regulatory Regime for a discussion of commercial domicile. If a large portion of the target's current or past premiums have been written in a state other than the target's jurisdictional domicile, counsel will have to analyze such state's commercial domicile rules to determine if any activity thresholds have been exceeded.
- *Permitted practices*. The acquirer's counsel should understand if there are any "permitted practices" that regulators have approved for the target. Permitted practices are case-by-case exemptions to insurance rules that regulators may grant at their discretion. For example, a shell insurance company without meaningful operations may be exempted from filing audited annual statutory statements. Additional diligence may be warranted to cover any gaps in oversight that such regulatory relief may have created.
- *Regulatory filings*. Another aspect of the regulatory due diligence is review of regulatory filings made by the target and correspondence received from regulators in connection with those filings. The insurer's insurance holding company system filings will be of particular interest (see the discussion of these filings in Insurance Holding Company System Model Act and Regulation). Counsel should also review the target's quarterly and annual statutory statements, which will reveal more than financial information. These statements contain valuable information about affiliate agreements, material reinsurance contracts, paid dividends and distributions, and other key matters. The management discussion and analysis filed in connection with the annual statutory statements and the auditor's report on the annual statutory statements may also contain crucial information about the condition of the company.
- *Orders and undertakings*. If the regulator has deemed it necessary to intervene in the target's operations, such intervention often takes the form of an order or, if the target is cooperating, a consent order or agreement to undertake certain action. If any such orders or undertakings exist, counsel will want to review them.
- *Examinations*. Regulators conduct periodic financial and market conduct examinations of the insurers in their domiciliary state. The reports from such examinations can be very informative with respect to the target's finances and its market activities.

Another aspect of regulatory due diligence, which can sometimes be hard to assess, is the strength of the relationship between the target and its domiciliary regulator. Considering that the regulator plays a central role in monitoring the target's operations, and is in a position to approve many aspects of the target's activities (e.g., the payment of extraordinary dividends, affiliate contracts, new product development, rate and form filings), the acquirer will need to understand what kind of relationship the target has developed with the regulator. Such analysis could give the acquirer helpful leads about the severity of the target's regulatory shortcomings, if any. It could also be useful to understand if certain officers and staff were responsible for creating a cordial and trustworthy relationship with the

regulator, in order to consider if such officers and staff should be retained. Contacts with insurance regulators are in many ways more complex than those with regulators in other industries and, unlike a difficult third party, a regulator cannot be replaced by the insurer. Most insurance companies understand the need for good regulatory relationships and are wary of pushing the envelope in these dealings. Counsel should be mindful that clients may have spent considerable time and effort building a strong relationship with a regulator and should not jeopardize that relationship.

## Collectability of Reinsurance

A common form of counterparty risk to which insurers are subjected is the risk that its reinsurers are unable or unwilling to pay claims made by the insurer under reinsurance agreements. Regardless of whether the reinsurer is able to pay a reinsurance claim to the insurer, the insurer will be liable under the policy issued to the policyholder. In other words, the nonperformance of the reinsurer is not an excuse for nonperformance by the insurer. Accordingly, an insurer that has paid reinsurance premiums to a reinsurer that is or becomes insolvent, or for any other reason fails to pay under a reinsurance agreement, would be subject to a dual financial setback: the loss of the reinsurance premium and the loss of reinsurance coverage. In addition, loss of reinsurance for which the insurer had previously taken credit on its balance sheet for regulatory reserving purposes could result in the insurer being forced to raise additional capital or secure alternative reinsurance arrangements to address the loss of the reinsurance credit. For the acquirer it will therefore be important to scrutinize the target's reinsurers, including assessing their ratings, payment history, and any disputes with the insurer and others, along with other factors bearing on the reinsurers' creditworthiness and solidity.

## Composition of the Investment Portfolio

As part of its financial due diligence review of the target, the acquirer will want to review the composition and nature of the target's investment portfolio to ensure that the asset classes, level of concentration, and liquidity of the investment portfolio are consistent with the target's investment guidelines and appropriate for an insurer of its kind. The acquirer must also ensure that the target matches investment asset yields with policy payout obligations. This task is particularly important for life and annuity insurers that have written policies with minimum guaranteed benefits. If the amount promised under a guaranteed minimum benefit policy is higher than the asset yields, the insurance company is at risk of incurring steady losses on such policies.

## Dependency on Intercompany Arrangements

Many smaller insurance companies are legal and financial vehicles without operational personnel, assets, or facilities of their own. In those cases, it is common to source services (e.g., financial, reporting, accounting, and legal services), staff, information technology, and physical space from an affiliated company. If the target will be separated from its larger group, the acquirer must understand to what extent those services need to be replaced after closing. In addition, affiliates of the target may be providing financial support through intercompany guarantees or capital maintenance agreements. Such affiliate financial backing could underpin financial strength ratings, letters of credit issued by banks to support excess reserve financing, and comfort to regulators. The acquirer should expect that it will be required to meet these commitments or arrange for them to be met by the seller and its affiliates during a transition period.

## Data Security and Privacy Laws

In recent years, there have been an increasing number of instances in which customers' personal data have been compromised. Prominent examples include Equifax (148 million consumers' personal information stolen), LinkedIn (165 million user accounts compromised), Marriott (data pertaining to up to 500 million costumers accessed), Sony (data from 100 million user accounts stolen), and Anthem (between 60 and 80 million customers' data compromised). Losses from data breaches can include (i) direct costs, such as costs of investigation and remediation, discounts to maintain customers, fines, litigation costs, and damages; (ii) indirect costs, such as decline in sales and stock price; and (iii) intangible losses, such as reputational damage and loss of business opportunities. Insurance companies are particularly attractive targets because of their information-rich databases and networks.

To address the increasing incidents of data breaches and the resulting exposure to licensed insurance entities, in March 2017, the New York Department of Financial Services (DFS) adopted a new regulation, "Cybersecurity Requirements for Financial Services Requirements." Soon after, in October 2017, the NAIC adopted the "Insurance Data Security Model Law," which resembles the New York cybersecurity regulation in most respects. The New York DFS regulation and NAIC model law protect three types of nonpublic information: (i) business related information of a licensee the tampering with which, or unauthorized disclosure, access, or use of which, would cause a material adverse impact to the business, operations or security of the licensee; (ii) personally identifiable information of consumers; and (iii) protected health information of consumers. The New York DFS regulation and NAIC model

law require most insurance licensees in a state to develop and maintain a written cybersecurity policy and implement a risk-based cybersecurity program. The New York DFS regulation and NAIC model law also require a licensee to satisfy specific requirements related to:

- Risk assessment and management
- Oversight of third-party service providers
- Incident reporting, investigation, and notification – and –
- Annual certification

As suggested above, the New York DFS regulation and NAIC model law apply to more than just insurers, and cover most other types of business entities and professionals that are licensed under the insurance laws of a state – including insurance agents and brokers. The New York DFS regulation and NAIC model law do, however, exclude from their scope purchasing groups and risk retention groups that are chartered and licensed in another state, and insurers that are only assuming business in the state as reinsurers and are domiciled in another state. As of June 2021, Alabama, Connecticut, Delaware, Indiana, Louisiana, Maine, Michigan, Mississippi, New Hampshire, North Dakota, Ohio, South Carolina, Tennessee, and Virginia had enacted some version of the NAIC model law. The NAIC model law has been well received at the federal level, with the Department of the Treasury strongly endorsing the model law and recommending that the U.S. Congress considers adopting federal legislation that would preempt state law if the model law is not generally adopted by the states in the near future.

The due diligence review of a target's data security standards should therefore focus not only on its preparedness and response to cyber-attacks, but also on its maintenance and implementation of policies and procedures for preventing and mitigating the effects of lost devices and employee breaches—whether intentional or unintentional, and whether the target company is in compliance with applicable state laws based on or similar to the NAIC model law. For legal counsel, the due diligence review could consider a whole spectrum of issues, such as:

- Whether the target has a written information security policy and whether the policy is on par with industry practice
- Whether the target has a chief information security officer or similar function
- Whether the target carries cyber insurance
- Whether sensitive data is shared outside of the target with third parties and what such third parties do to protect such data
- What procedures the target has in place for determining whether a data breach has taken place
- Whether there have been any known security breaches
- How the target is responding to or has responded to any breaches – and –
- The extent to which the target has complied with data security laws and regulations

In addition to data security breaches, other privacy matters pose significant concerns for insurance companies. In its due diligence review, the acquirer should examine how the target uses personal information and to what extent such information is disclosed to the public and third parties. The acquirer should also determine in what jurisdictions such personal data is collected, stored, and used, and should analyze legal compliance issues in connection with such practices. Part of that analysis should consider if data transfers will occur as result of the acquisition of the target, particularly if such transfer will occur over state and national borders. For example, the EU's Directive 95/46/EC provides certain limitations on personal data transfers outside of the European Economic Area. The General Data Protection Regulation (GDPR), which took effect in 2018, applies data privacy rules to organizations within the EU as well as those located outside the EU if they offer goods or services to, or monitor the behavior of, EU data subjects. In the U.S., California enacted the California Consumer Privacy Act, which became effective in 2020 and aims to give residents of the state the right to know what personal data is being collected and how such data is being used. The law also provides the ability for consumers to control certain uses of the data. The law applies to any business operating in California that has annual gross revenue in excess of $25 million, controls or transfers personal information of 50,000 or more consumers, or earns more than half of its annual revenue from selling consumers' personal information.

It is also important to consider what information is shared by the seller and the target with the acquirer during the due diligence phase. The seller is well advised to avoid sharing any sensitive personal information about customers and employees with the acquirer prior to the closing. Depending on the context and applicable jurisdiction, information such as Social Security numbers, driver's license numbers, credit card numbers, medical information, addresses, and names could be deemed protected information. Sharing such information with the acquirer could breach the target's customer and employee privacy guidelines and policies, could trigger notification and consent requirements to customers and employees, and could be an outright violation of privacy laws. If certain information is deemed to be appropriate to disclose to the

acquirer, the seller should ensure that any such information is subject to a non-disclosure agreement signed by the parties prior to the due diligence phase and that secure means of transmission are used.

### Reserve Financing

Counsel in a life insurance M&A transaction should diligence the extent to which the target uses captive reinsurers to meet the capital reserve regulatory requirements in Regulation XXX. Similar requirements for certain universal life policies with secondary guarantees are known as Regulation AXXX. Regulations XXX and AXXX are currently reserve standards in all states.

The perception of the life insurance industry was that the reserves mandated by Regulations XXX and AXXX were significantly in excess of the "economic" reserves considered necessary by the industry to satisfy insurers' obligations to policyholders. For life insurers, posting "redundant reserves" in highly conservative investments reduced their rate of return on capital and was seen as a waste of capital. Against this backdrop, life insurers started to develop ways to free up capital from these redundant reserve requirements through securitization techniques. In a typical Regulation XXX or AXXX securitization, the insurer forms a wholly owned special purpose reinsurer, licensed as a captive reinsurer, and cedes the policies to which the redundant reserve requirements apply to the captive reinsurer. The reinsurer is financed partly by the insurer, but mostly through a third party. In the early stages of Regulation XXX and AXXX securitizations, securities that were guaranteed ("wrapped") by a bond insurer like Ambac or MBIA were issued to the capital markets to fund the reinsurance captives. However, after the global financial crisis, which caused many bond insurers to cease writing new business, capital market funding for this financing became harder to come by. Insurers turned to financial institutions instead. Today, a captive reinsurer's obligations under a reinsurance agreement are typically supported by a letter of credit or contingent note provided by a third-party bank in exchange for a fee paid to the bank. Regulation XXX and AXXX transactions must be approved by both the insurer's and the captive reinsurer's domiciliary states in order for the insurer to receive credit for reinsurance on its balance sheet. Credit for reinsurance mitigates the capital strain on the insurer from the redundant reserves, thus accomplishing the primary purpose of the transaction.

With the increase in these types of transactions, media and regulatory scrutiny intensified. The NAIC adopted rules governing life reserve financing transactions in 2014 in Actuarial Guideline XLVIII (AG 48). AG 48 is intended to: (i) permit life insurers to continue to pursue capital relief opportunities through third-party financings; (ii) establish some uniformity among jurisdictions and regulators for the review and approval of such financings; (iii) facilitate transparency regarding such financings; and (iv) add enhanced policyholder protections to such financings by way of increased liquidity and solvency margins. The NAIC has also been trying to tackle the core issue of reserve requirements. In 2016, the NAIC implemented principle-based reserving through revisions to its Standard Valuation Law, which has been enacted by most states. Principle-based reserving moves away from formulaic reserve requirements and is in some ways less conservative. During a transition period, principle-based reserving was optional for life insurers that were subject to the Standard Valuation Law. As of January 1, 2020, however, the new reserving regime has become mandatory in states where the law applies (although smaller insurers may be granted exemptions). See also the related discussion regarding "covered agreements" in ***The Regulatory Regime***.

In light of the regulatory change surrounding the use of captive reinsurers and reserve requirements, the acquirer needs to understand the following in any M&A transaction:

- To what extent the life insurer uses captive reinsurers to relieve capital strains
- Whether the captive reinsurer will follow along with the insurer in the transaction
- To what extent the seller is willing to continue providing the supporting structure (e.g., parental guarantee, if applicable) to give the acquirer time to replace the structure, and what replacement funding alternatives are available
- The terms of the captive arrangement (e.g., with respect to change of control provisions and reporting and capital maintenance covenants to a third-party issuer of a supporting letter of credit)
- Regulatory implications of a change of control of the captive structure – and –
- How the new reserve requirements affect the life insurer financially and operationally (e.g., the complex calculations of the new reserve regime will likely require substantial changes to the insurer's processes, information technology systems, and internal controls)

## The Purchase Agreement

The purchase agreement in an insurance M&A transaction must address both the unique nature of the insurance business and the regulatory framework in which the industry operates. The following discussion highlights

common issues that arise in the drafting and negotiation of insurance M&A purchase agreements. As noted in the Introduction, the following discussion assumes an outright acquisition of a stock insurance company.

## Common Purchase Price Mechanics and Features

As discussed in Insurance Holding Company System Model Act and Regulation, an acquirer is required to file a Form A application with the target's domiciliary regulator after signing the purchase agreement, and must obtain the regulator's approval prior to closing. Therefore, insurance company acquisitions will have separate signing and closing dates. Form A approval can take months or in some cases beyond a year. Consequently, the acquirer will want to ensure that any diminution in the target's value between signing and closing is reflected in the purchase price. Conversely, the seller will want to make sure that any increase in the target's value during such period is also reflected in the purchase price. On rare occasions, the seller and the acquirer will agree on a "locked box" structure, where the value of the target is determined at signing (usually based on recently audited financial statements), sometimes with the addition of an interest rate component.

Because insurance regulations require insurance companies to prepare financial statements based on SAP, these financial statements usually form the basis for the acquirer's determination of the target's value. Some insurance company targets, particularly if they are listed on a stock exchange or if non-insurance companies are included among the companies being acquired, will also have financial statements prepared in accordance with GAAP. In those instances, the acquirer may base the valuation of the target on GAAP. If that is the case, more traditional purchase price methodologies could be appropriate and provide for post-closing adjustments based on the target's working capital or GAAP net worth. The following discussion addresses purchase price adjustment benchmarks that are more specific to insurance M&A.

*Statutory Book Value*. A common method of purchase price adjustment in an insurance transaction is to gauge the difference in the target's book value between a benchmark number and the value at closing. The book value of a company is meant to reflect the value of assets that its shareholders would theoretically receive if the company were liquidated the next day. In the insurance M&A context, the book value of the insurer is often adjusted based on SAP (e.g., by excluding non-admitted assets and including special liabilities like reinsurance from unauthorized reinsurers, and adding or subtracting reserve redundancy or reserve inadequacy). Because the calculation of reserves is rather subjective, the parties may have very different views on whether the target's current reserves are adequate or not. This may be particularly true for long-tail liabilities, such as asbestos and environmental liabilities, or for long-term liabilities such as life and annuity liabilities.

*Risk-Based Capital Ratio*. Because the RBC ratio is a determinative element for regulatory intervention and is perceived as a reliable measurement of an insurance company's financial health, an insurer's RBC ratio is sometimes used as a benchmark in setting and adjusting the purchase price. Since the calculation of the RBC ratio requires a rather complex analysis of the insurer's capital adequacy and risk profile, counsel's close collaboration with the parties' financial experts is strongly advised when formulating a purchase price adjustment based on a target's RBC ratio.

## Key Representations and Warranties

The representations and warranties given by the seller in the purchase agreement typically focus on the target's nature and operations, issues arising in due diligence, and matters related to the target which the seller would be in the best position to know. The items below are common points for negotiating the representations and warranties in an insurance M&A purchase agreement. For more general discussion of representations and warranties in an M&A transaction, see Representations and Warranties in Acquisition Agreements.

*Qualification of the Target*. Most M&A agreements include a seller representation regarding the organization or incorporation, qualification, and authority of the target company. Such representations often state that the target is duly qualified as a foreign corporation to do business in each jurisdiction where the nature of its activities makes such qualification necessary. However, in the case of an insurance company target, the wording of that representation could be read to encompass more than just corporate or organizational authority. With a few exceptions (e.g., insurance written on an "excess line" or "surplus line" basis), an insurance company that seeks to conduct insurance operations in a particular state must be licensed in that state for the lines of insurance the company is offering. It is quite possible that a court would view the wording of the representation set out above to also apply to insurance licenses. As such, a deficiency, suspension, or withdrawal of an insurance license could cause this seemingly innocuous representation to be breached. Considering also that the qualification representation is commonly given status as a "fundamental representation," where recourse for its breach could give the acquirer the right to walk away from the transaction or be indemnified

without threshold and cap limitations, narrowing the scope of the representation to exclude insurance license deficiencies is essential for the seller. Counsel to the seller should also be mindful of any intended or unintended backdoor representation coverage of insurance licenses. Note that the representation catalog typically includes a representation regarding "permits," where license representation is primarily intended to be covered.

*Governmental Consents and Approvals.* As previously discussed, the insurance industry is more regulated than most other industries. Therefore, the representation covering governmental approvals included in an insurance M&A agreement should take into account all necessary filings to be made and consents to be received in connection with the transaction. This representation will typically focus on the filings and consents required in connection with the domiciliary state's regulations (see the discussion in The Insurance Holding Company System Model Act and Regulation). Note also that filings and approvals in other states may be necessary. For example, if the target is commercially domiciled in another state, or if the transaction could have anti-competitive effects in another state, filing a Form A or Form E would be required in that state. It should also be noted that regardless of whether Form E filings are required, a federal Hart–Scott–Rodino filing and waiting period may still apply. See Merger Review Antitrust Fundamentals.

*Regulatory Compliance.* Naturally, the acquirer will want the seller to represent that the target has been and is in compliance with laws. More specifically, the acquirer will want the seller to represent that the target has complied with a host of regulatory matters, such as having made all required regulatory filings, received regulatory approvals to such filings where needed, complied with regulatory requests and orders, and resolved any requests or orders issued. The acquirer will also want the seller to confirm that there are no consent agreements or other agreed undertakings in effect with any regulator.

Another central aspect of regulatory compliance has to do with the target's certificates of authority (i.e., insurance licenses) required to operate in the jurisdictions and insurance segments where the target is doing business. The acquirer will want the seller to represent that the certificates of authority are valid and in full force and that there are no current circumstances that are reasonably likely to lead to any of those certificates being withdrawn or suspended (e.g., written notice of violation from a regulator or failure by the target to satisfy express conditions of any certificate of authority). In addition, the acquirer will want to obtain a list of all certificates of authority of the target (and any other insurance companies being acquired in the transaction) and confirm that the list's accuracy and completeness are backed by a representation from the seller.

The acquirer may desire more specific and thorough representations such as the following:

- Target's marketing and sale of insurance products is in compliance with applicable laws, in particular with respect to (i) advertising and sales practices and (ii) approval of required policy form and rate filings by applicable insurance regulatory bodies.
- No third-party producer has authority to bind the target to issue insurance products to policyholders without the target's approval.
- All third-party producers are adequately licensed, in compliance with market conduct rules, and acting within the scope of the authority granted by the target.
- No compensation is being paid to unlicensed persons for selling insurance products for the target.
- Target has made payment for, or is in the process of handling in the ordinary course, all valid policy claims.
- There has been no intentional withholding of amounts from policyholders, and no objections to payment by the target without a reasonable basis to contest such payments.

The acquirer may also want the seller to list a certain number of its largest revenue generators and make representations as to the accuracy of such list in order to backstop due diligence findings on the target's most important producers.

*Financial Information.* An insurer must prepare financial statements in accordance with SAP for submission to the regulator on a quarterly and annual basis. These are known as statutory statements. Unless the insurer has applied for and received an exemption, the annual statutory statements must also be audited. A representation on financial information would therefore typically cover at least the last annual audited and interim quarterly statutory statements, and whether any permitted practices apply to such statements. Insurers that are part of a holding company system commonly have two accounting regimes, SAP and GAAP, serving different purposes. The acquirer would be wise to have the representation cover both these sets of financials, particularly if the valuation of the target is based on GAAP accounting.

*Reserves and Actuarial Studies.* A hotly contested area in insurance M&A agreements is to what extent the seller will make representations regarding the reserves set aside by the target to pay for incurred or future insurance liability.

The seller will try to resist making any representations regarding such reserves, contending that (i) assessing the adequacy of reserves is inherently subjective and (ii) many elements of reserve assessment are outside the control of the seller and the target. The acquirer, on the other hand, will want to make sure that the reserves have been computed in accordance with generally accepted actuarial principles and in compliance with applicable regulations and that the actuaries calculating the reserves had access to correct and complete information. If the seller or the target hired outside actuaries to assess the adequacy of the target's reserves, the acquirer should also seek a representation from the seller that any reports regarding reserves generated by those actuaries are accurate and complete.

*Reinsurance Arrangements*. One of the principal risk management tools of an insurer is to spread its insurance risk to other parties through reinsurance arrangements. By ceding underwritten policy liabilities to reinsurers, the insurer limits its exposure to the portion of the written policies retained, subject to the credit risk of the reinsurer. The target may also have assumed, as a reinsurer, business from other insurers. If the underlying business is underwritten and managed well, reinsuring the underlying business can be very lucrative.

The insurance M&A agreement often contains separate representations regarding reinsurance. The acquirer should ensure that both ceded (outgoing) and assumed (incoming) reinsurance contracts are covered. The acquirer will want to include assurances regarding the validity and effectiveness of the reinsurance agreements, similar to the representation the seller will be providing with respect to material contracts. The acquirer will also ask the seller to represent that no reinsurer is impaired or has other financial difficulties. The seller, on the other hand, will view such risks as common business risks inherent to the ownership of an insurance operation and will try to reject such representations.

Finally, the acquirer may request a seller representation that the target is entitled to take credit on its statutory statements for its reinsurance agreements. The point here is that if credit cannot be taken on the target's statutory statements for such reinsurance agreements, the acquirer may have to post other assets to satisfy the target's capital and surplus requirements under state insurance laws. Consequently, if the target or its reinsurers are not in compliance with the credit for reinsurance rules, it can be costly to make up an unexpected shortfall in capital and surplus of the target.

*Data Security and Privacy Laws*. As discussed in Due Diligence in Insurance M&A Transactions, data security and privacy issues have gained attention in the insurance industry during the last few years. In 2017, the NAIC adopted a Data Security Model Law which approximately 20 states have since enacted. In addition, New York passed its own, stricter, law which requires insurance companies, agencies, and brokerages operating in New York to implement data security standards. The seller's representations in the purchase agreement will typically reflect this. The acquirer will want to ensure that the representations cover the integrity of the target's hardware and software for data security and the target's adoption and implementation of robust security policies and procedures. The acquirer will also want the seller to represent that no data security breaches are known to have occurred and that there is no reason to believe that such breaches have occurred. Considering that most data breaches are not discovered upon occurrence, and that it could take months or years for a breach to be detected, the acquirer may want to extend the survival period for such data security representations. The acquirer may also request representations regarding adequate insurance for data security and cyber-attacks.

The acquirer will also ask for robust representations on the target's policies and procedures to safeguard policyholder and consumer privacy information. For some insurers, there is an additional layer of regulatory obligation. For example, health insurers' use and disclosure of customer information are subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The acquirer will want to ensure compliance with any such regulations.

*Separate Accounts*. The term "separate account" refers to assets held by a life insurer that are maintained separately from the insurer's general assets. Separate accounts were originally established in response to federal securities laws for investment-linked variable annuities, but their application has grown beyond these products. Assets in a separate account are earmarked to satisfy the insurance company's liabilities under variable life insurance policies and variable annuities. The holders of such policies select specific investment strategies for the separate account assets and bear the associated investment risks. Separate accounts can be subject to filings with the SEC. The representation will typically cover the separate accounts' compliance with federal securities laws.

## Key Covenants

Pursuant to the covenants in the purchase agreement, the parties commit to perform (or refrain from performing)

certain actions after signing and up to closing. A primary purpose of this practice is to ensure that the closing conditions will be satisfied and the acquisition will close. In most M&A transactions, the heaviest burden of the covenants is on the seller. For example, the seller may be required to restructure the target, notify third parties of the transaction and obtain necessary third-party consents, and terminate or discharge intercompany agreements and balances between the seller or its affiliates and the target. In addition, the acquirer will want to ensure that the target is not operating in a manner outside of the ordinary course of business and that extraordinary actions—such as stock issuances or reclassifications, changes in accounting practices, or the sale of significant assets—are not undertaken prior to closing. The following are some issues specific to covenants in insurance M&A transactions. For more general discussion of covenants see Covenants in Acquisition Agreements.

*Efforts to Obtain Governmental Approvals.* Unlike most other pre-closing covenants, the provisions addressing the parties' efforts to obtain governmental approvals is a covenant that places obligations mainly on the acquirer, rather than the seller. The acquirer is required to file the Form A application and be approved as the target's new owner. However, the seller is typically obligated to cooperate with the acquirer in preparing and gathering necessary information about the target for the Form A application.

A question that often arises in connection with Form A approval is the extent to which the acquirer and seller will be obligated to satisfy requirements or conditions imposed by the domiciliary regulator in connection with approval of the Form A filing. Regulators (sometimes under pressure from policyholder groups and other stakeholders) may view an acquirer as less financially stable than the seller, for reasons ranging from the acquirer having an inexperienced management team to poor credit ratings and a less robust balance sheet. Under such circumstances, the regulator may impose requirements or conditions for granting the Form A approval. For example, it may require that additional capital be contributed to the target as a condition for approving the transaction. The parties should address in the purchase agreement how to resolve such requests or "burdensome conditions," and to what extent they will be contractually obligated to satisfy such conditions. From a drafting perspective, this can be problematic, since the purchase agreement will be submitted to the regulator with the Form A application, and thus any agreed-upon terms related to regulator conditions will be known to the regulator. The regulator may use that information to shore up policyholder safeguards or impose other conditions consistent with what the parties have contractually signaled that they are willing to accept. However, such considerations should not be overstated, since the regulator will make its own assessment of the capital needs of the target going forward, often hiring its own actuaries to conduct an independent review of reserve adequacy.

*Investment Assets.* The acquirer will have an interest in reducing the risk associated with the target's investment portfolio and in having flexibility with respect to the investments. Therefore, the acquirer will sometimes ask that the seller liquidate the target's investment portfolio into cash or cash equivalents between signing and closing. At the very least, the acquirer will want to make sure that the seller ensures, during the pre-closing period, that the target does not engage in investment practices that have not been agreed upon by the seller and the acquirer in a separate investment policy document, or that the target's investment policies are consistent with past practice. In short, the acquirer does not want any unexpected negative swings in the investment portfolio, especially if the performance of the investment portfolio is not subject to purchase price adjustment. The seller, on the other hand, may not want to liquidate the target's portfolio if doing so would realize losses, or may want to refrain from liquidating the portfolio until the seller is certain that the transaction will close. In larger transactions, liquidating a large investment portfolio may also be costly and inefficient. The seller may view the nature and allocation of the investment portfolio as fully adequate and may argue that the acquirer will be in a position to make any changes it sees fit once the acquirer has assumed control of the target.

*Seller Guarantees.* Insurers and their insurance and reinsurance subsidiaries often rely on guarantees from the insurer's parent company or the parent's affiliates to support their operations. Such guarantees could be in place to support a credit rating or a letter of credit issued to support reserve financing, or could be the result of an agreed undertaking with regulatory authorities. The seller will want to terminate any such arrangements at closing. The acquirer is typically sympathetic to the seller's view, but may not want all terminations of seller guarantees to be closing conditions. Instead, the acquirer may indemnify the seller for any parental guarantees that the parties have not been able to replace or terminate by closing, and the acquirer may undertake to make efforts to replace or help terminate the guarantees as promptly as possible.

*Insurance-Specific Interim Operating Limitations.* Virtually all M&A agreements dictate how the seller is allowed to operate the target in the period between signing and closing. These covenants, sometimes referred to as "interim operating limitations," usually require the seller to operate the target in the ordinary course of business

and refrain from taking certain enumerated actions. Many of the interim operating limitations in an insurance M&A transaction will be identical or similar to those in other M&A transactions. In addition, insurance M&A purchase agreements also often include covenants requiring the target not to:

- Terminate, fail to renew, or let lapse any certificate of authority or other insurance license
- Change the terms for payment of commissions to any insurance agents, brokers, or producers
- Modify its insurance policy forms in a manner resulting in a material change in risk or coverage
- Modify any reinsurance agreement or treaty resulting in a material change in risk or coverage
- Reduce any insurance reserves other than as required by SAP, or change the reserve methodologies or practices
- Make any changes to underwriting or claims handling practices – and –
- Make any changes to its investment guidelines or policies

*Reserve Financing.* In insurance M&A transactions involving a life insurer that is using one or more captive reinsurers to relieve capital strains caused by Regulations XXX and AXXX (see Due Diligence in Insurance M&A Transactions – Reserve Financing), the parties will want to address how the transfer or replacement of such arrangements will be handled. Most of today's captive reinsurer transactions are backstopped by a letter of credit issued by a financial institution. The parties should consider whether the acquirer will be able to continue using that arrangement after closing. If not, the parties will want to agree on how the arrangement shall be replaced and the timeline to complete replacement. If a replacement structure is contemplated, the parties should consider who will be responsible for the initial funding of the new captive reinsurer and the costs for issuance of the new letter of credit. The parties should also explore what regulatory filings and approvals are required for such replacement and the obligations of the parties in connection therewith.

## Key Closing Conditions

Purchase agreements in an insurance M&A transaction tend to include many of the same closing conditions that one would find in purchase agreements in other industries, such as confirmation that the representations and warranties are accurate in all material respects, that pre-closing covenants have been satisfied in all material respects, that antitrust law clearance has been received, that there is no injunction or order preventing the transaction from consummating, and that no material adverse effect has occurred. See Conditions to Closing in Acquisition Agreements. The acquirer in an insurance M&A transaction may also seek additional closing conditions to address insurance-specific regulatory and business concerns, such as the following.

*Receipt of Governmental Approvals without Burdensome Conditions.* As noted in Key Covenants – Efforts to Obtain Governmental Approvals, the acquirer will seek approval of the transaction from the target's domiciliary regulator by filing a Form A application with the regulator upon signing the purchase agreement. The acquirer's receipt of approval of the Form A filing should therefore be included as a closing condition. Moreover, the acquirer will typically be mindful of the nature and substance of such approval. A Form A approval can impose certain conditions on the parties (typically on the acquirer as the new presumptive owner of the target). For example, the domiciliary regulator could condition the approval on the acquirer's establishment of a separate trust with investment assets to be held for the benefit of the target or on the acquirer's contribution of additional capital to the target. Therefore, the acquirer will often try to negotiate a closing condition that states that the Form A approval shall have been received and does not include any "burdensome conditions" or similar wording. The definition of "burdensome conditions" as it relates to the closing condition section of the purchase agreement will often mirror the acquirer's covenant regarding efforts to obtain governmental approvals. If the seller agrees to a "no burdensome conditions" concept, it will generally focus on limiting the parameters of what constitutes a "burdensome condition."

*Termination of Seller Guarantees.* The seller may have provided capital maintenance commitments or other parental guarantees for the benefit of the target as support for credit ratings or letters of credit issued or due to regulatory mandates. The seller, who will no longer receive any benefits from the target's operations after closing, will naturally want to ensure that such seller guarantees are terminated at or prior to closing. Depending on the type of parental guarantee, the seller may require that the termination of such guarantees be added as a closing condition if, for example, such termination effectively requires prior approval of a regulatory body.

*Financial Metrics.* Financial institutions, including insurance companies, live and die by financial metrics. For example, if an insurer's RBC ratio falls below 200%, it will likely be subject to intervention by the domiciliary regulator. From the acquirer's perspective, a purchase price adjustment tied to the target's RBC ratio (which would allow the acquirer to pay a lower purchase price for the target if the RBC ratio dipped) may not be wholly satisfactory. Consequently, the

acquirer may require that the RBC ratio be 300% or higher at closing to avoid having to address an RBC ratio problem at the outset of its ownership of the target.

*Ratings.* In situations where the target's financial strength ratings are critical to its operations, it is not uncommon for the parties to agree to include a closing condition that indicates the lowest allowable financial strength rating of the target. Such ratings conditions typically stipulate that the target has neither been placed on a rating agency watch list nor had its rating qualified with a negative outlook.

### Post-closing Recourse

Indemnification and other post-closing recourse provisions included in an insurance M&A agreement are comparable to those seen in other industries. See Indemnification Provisions in Private Acquisition Agreements. Provisions included to address insurance-specific concerns are described below.

*Specific Indemnities.* An M&A transaction can include unlimited indemnity protection for specific events and circumstances, for which the acquirer requests that the seller take the risk. In an insurance transaction, common areas for specific indemnities are:

- Policyholder claims for extra-contractual obligations or claims in excess of insurance policy limits – and –
- Certain types of litigation common in the insurance industry, such as litigation with insurers or reinsurers involving large reinsurance claims and class action policyholder lawsuits, or regulatory actions initiated against the target for improper conduct of business such as false advertisement and discriminatory underwriting

*Certificates of Authority in Shell Company Deals.* If an acquirer is acquiring a shell company without meaningful operations, it will often try to strengthen the indemnification provisions backstopping the validity of the target's certificates of authority. The rationale for this is that the sole purpose of a shell company acquisition is to acquire the target's certificates of authority. The strengthening of the indemnification provisions can be done in numerous ways, including by extending the survival period for the seller's representations regarding such certificates of authority to give the acquirer additional time to evaluate their validity. This can be done by providing that defective certificates of authority will be covered by a specific indemnity (outside the limitations imposed by baskets and caps), or by providing that any defective certificates of authority will result in a purchase price deduction.

*Fronting Arrangements.* Sometimes the seller, or a seller-affiliated insurance company that is not included in the transaction, has been writing business out of a state where the target does not have a certificate or authority to do so. Nevertheless, the parties may have agreed that the business written by the seller or its affiliate should pass to the acquirer in the transaction through a reinsurance arrangement. Since the target does not have a certificate of authority to write business in the state, and it would take time for the target to acquire such certificate, the seller may agree to "front" renewals of existing business for the acquirer during a set period of time or until the target is able to write such renewals itself. Under such circumstances, it is not uncommon for the seller to require the acquirer to indemnify it and its affiliates for any losses incurred in connection with providing such fronting services.

## Post-closing Matters

The following post-closing matters are sometimes made part of an insurance M&A transaction, either through incorporating relevant provisions in the covenants section of the purchase agreement or through ancillary agreements that are executed at closing.

### Fronting Arrangements

As discussed in The Purchase Agreement – Post-closing Recourse, in cases where a reinsurance agreement transfers underwritten business from an insurance company to another party that cannot write its own business in a particular jurisdiction, the ceding insurer may agree to write renewal policies, or "front" for the other entity until it is able to write its own renewal policies. Consequently, the fronting arrangement is designed to avoid unnecessary interruption and loss of business during a transitional period. If a fronting arrangement is necessary, the seller and acquirer should include post-closing covenants in the purchase agreement to address the period of time during which the fronting services will be provided, under what circumstances the ceding insurer's obligations to provide the fronting services will be excused, and what level of effort the assuming entity is required to make to ensure that the required licenses are eventually obtained. As the provider of the fronting services, it will be important to the fronting company to assess how the fronting arrangement will affect the capital requirements during the transitional period and how business risk related to the fronting arrangement is being shared between the parties. It should be noted that depending on the transaction structure and the circumstances, both the seller and the acquirer could require fronting services from the other.

### Trademark Issues

If the target uses or has used trademarks or trade names that belong to the seller and its affiliates and that are not being transferred to the acquirer in the transaction, the seller will want to ensure that the target does not use such trademarks and trade names after closing. The acquirer, on the other hand, should make sure that it will not be deemed to have infringed the intellectual property rights of such trademarks and trade names during the period that such trademarks and trade names are being phased out or being changed. A name change of an insurance company often requires regulatory approval and multistate filings. In addition, material used by the target, such as policy forms, will likely also have to change. Such changes can also require governmental approval. Although the seller will want to ensure that the target and the acquirer do not use the retained seller trademarks after closing, the acquirer wants to give itself sufficient time to phase out such trademarks and receive any governmental approvals required for such changes.

### Post-closing Filings

Not all filings made in connection with an insurance M&A transaction are required to be filed prior to closing. For example, many states require an insurance company that is licensed (but not domiciled) in the state to file a notice with the state insurance department following a merger or acquisition. Many states require or accept a standard NAIC form called the Corporate Amendments Application for this purpose.

### Transition Services Arrangements

A central aspect of any M&A transaction is to what extent the target is self-sufficient and able to operate on its own after the closing. The acquirer will want to determine during the due diligence phase what additional resources will be needed by the target after the closing. To backstop such initial determination, the acquirer may attempt to include a seller representation regarding the "sufficiency of assets" of the target. This can be used to determine what the target lacks in terms of its ability to operate as a stand-alone entity. The acquirer will also be guided by the seller's representations regarding intercompany agreements and material agreements that will require third-party consent in connection with the transaction in order to assess what services and agreements may not be available to the target and the acquirer following the closing. In smaller insurance M&A transactions it is common for the target to have been operated as a pure financial entity without its own operating assets (e.g., employees, facilities, accounting, legal, and finance functions). If that is the case, the seller or an affiliate of the seller will likely have provided such core services by way of one or more service agreements. If the acquirer will be unable to provide such services to the target upon closing, it may need to negotiate a transition services arrangement with the seller so that the seller will continue to provide the services on a temporary basis after closing. In connection with negotiating and drafting a transition services agreement, it will be important for the acquirer to determine to what extent the target has relied on such services from affiliates. Such transition services agreements may be subject to Form D filings. See also Transition Services Agreements in M&A Deals.

### Tax Allocation

The target is also commonly a party to a tax allocation agreement with the seller and other affiliates to take advantage of joint group tax filings. Any such tax allocation agreement will be terminated in connection with the closing, and the acquirer will want to determine if a replacement tax allocation agreement with the acquirer and its affiliates should be entered into following closing. Such new tax allocation agreements may be subject to Form D filings.

For general discussion of post-closing issues, see Integration Planning in M&A Transactions.

## Notes on the Future of U.S. Insurance M&A

The disruptive effects of the COVID-19 epidemic arguably helped accelerate a process to modernize the insurance industry. In a survey of insurance executives conducted by Deloitte during the height of the epidemic, four out of five respondents believed that the outbreak had exposed shortcomings in their company's digital capabilities and transformative plans. Almost all of those respondents stated that they had already accelerated their particular company's digital transformation to maintain resilience in a changing world. Accordingly, investments in digitization and acquisition of insurtech assets are likely drivers of coming insurance M&A Moreover, according to a 2020 Bain & Company report, private equity firms have a combined $2.5 trillion worth of dry powder ready to be invested in M&A Recent transactions, particularly in the life insurance and insurance broker segments, show that private equity firms are on the lookout for insurance related assets. As economic fundamentals continue to improve following the passing of economic relief legislation and the subduing effect of the COVID-19 outbreak from increased vaccination rates, the insurance M&A market should be ripe for activity in the near future.

# Related Content

*Practice Notes*

- Representations and Warranties in Acquisition Agreements
- Merger Review Antitrust Fundamentals
- Covenants in Acquisition Agreements
- Conditions to Closing in Acquisition Agreements
- Indemnification Provisions in Private Acquisition Agreements
- Transition Services Agreements in M&A Deals
- Integration Planning in M&A Transactions


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Capital Markets. Representing issuers and underwriters in connection with public and Rule 144A offerings of debt, equity, convertible and hybrid securities in the US and Europe; continuously offered debt and equity programs; liability management transactions, including equity and debt self-tenders, exchange offers, and consent solicitations; particular emphasis on offerings by financial institutions, including banks, insurance companies, brokers and specialty finance companies, and cross-border offerings.

Mergers and Acquisitions. Counseling buyers, sellers, and financial intermediaries in connection with public and private acquisitions, joint ventures, divestitures, mergers, tender offers, and proxy contests.

General Corporate Practice. Advising companies regarding Securities Act and Exchange Act compliance, NYSE and NASDAQ compliance, corporate governance, and Sarbanes-Oxley Act matters.

Chambers USA noted that "Edward Best's 'extremely quick mind' makes him a popular figure among lawyers and clients alike. 'He is never stumped by a question . . ..'" Eddie has been described as "Aptly named, as he's one of the best in town," and as "A 'stand-out debt and equity' lawyer." Legal500 recommended Eddie in "Capital Markets — Debt Advice to Issuers" and "Capital Markets — High-Yield - Advice to Managers," noting that Eddie is "chief amongst [Mayer Brown's excellent partners]." Eddie is also listed in Who's Who Legal, Best Lawyers in America for Securities Law, the Guide to the World's Leading Capital Market Lawyers, The International Who's Who of Capital Markets Lawyers (2007), and the International Who's Who of Business Lawyers (2008). In addition, he has been named among the "Leading Lawyers" in Illinois in the categories of Corporate Finance Law, Mergers and Acquisitions Law, and Securities and Venture Finance Law.

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Larry Hamilton is a partner in Mayer Brown's Corporate & Securities practice and Insurance Industry Group in Chicago. He focuses his practice on mergers, acquisitions and regulatory compliance of insurance companies and investment companies, both in the United States and in offshore markets. In addition, he regularly advises clients in connection with reserve financings, insurance-linked securities, pension de-risking transactions and public and private offerings of equity, fixed-income and hybrid securities.

Larry has a 50-state insurance regulatory practice and has extensive experience negotiating directly with insurance regulators, helping clients overcome regulatory obstacles and gain approval for their proposed forms of business arrangements. Larry is also part of Mayer Brown's Insurance and Capital Markets Convergence subgroup, which uses the combined talents of the firm's insurance and structured finance practitioners to ensure that transactions take into account the customs and expectations of both markets. He regularly advises US and European financial institutions on the insurance regulatory issues associated with complex capital market and derivative structures, including techniques such as credit derivatives, "transformer" vehicles, synthetic CDO bonds, collateral trusts and special purpose reinsurance companies. Larry has been recognized by Chambers USA as among "America's Leading Lawyers for Business" since 2009, and the 2010 edition praised him for his "knowledgeable, thorough and prompt" approach. According to Chambers USA 2009, he is "the standout name in the firm's insurance [transactional and regulatory] practice." Larry has also been named to the 2012 lists of Illinois Super Lawyers and "Best Lawyers in America." Larry joined Mayer Brown in 1996.