David Sorensen
Financial Conduct Authority
12 Endeavour Square
London E20 1JN
By email: cp18-10@fca.org.uk

8 March 2019

Dear Mr Bartholomew

Re: BVCA response to FCA DP18/10 – Patient Capital and Authorised Funds

We are writing on behalf of the British Private Equity and Venture Capital Association ("BVCA"), which is the industry body and public policy advocate for the private equity and venture capital industry in the UK. With a membership of over 750 firms, the BVCA represents the vast majority of all UK-based firms, as well as their professional advisers and investors. Over the past five years (2013-2017), BVCA members have invested over £32bn into nearly 2,500 companies based in the UK. Our members currently back around 3,380 companies, employing close to 1.4 million people on a full-time equivalent basis ("FTEs") across the world. Of these, around 692,000 FTEs are employed in the UK. Of the UK companies invested in during 2017, around 83% were SMEs.

The BVCA is delighted to have the opportunity to respond to the FCA's Discussion Paper on Patient Capital and Authorised Funds (DP18/10). The shift from Defined Benefit ("**DB**") plans to Defined Contribution ("**DC**") plans that is currently underway in the UK pension sector is affecting the range of investment opportunities available to pension holders and the level of funding in patient capital such as venture capital and private equity funds. There are continuing barriers holding back DC pension savers from investing in illiquid assets, therefore, not providing such pension savers with the significant upsides that exposure to private assets can bring to an investment portfolio.

Significant upsides of exposure to private assets

The latest BVCA data shows that only a small proportion of the total capital raised by UK-based venture capital and private equity funds in 2017 was raised from UK pension funds. Of the £33 billion raised in total, just 3.7% was raised from UK pension funds. In contrast, 36.5% of the £33 billion came from overseas pension funds which included £10.5 billion (31.7% of the £33 billion) from overseas public pension funds.[1]

Data on the global pensions markets in 2017 from Willis Towers Watson[2] showed that the UK has the second biggest pensions market in the world with USD 3.1 trillion of pension assets. 28% of this amount was allocated to other asset classes including alternatives. The DB to DC pensions assets split was 81% to 19%. Therefore, there is potential for UK managers to raise more capital from UK pension funds in the future.

[1] Note that this number will not include fund managers that are not based in the UK. BVCA report on Investment Activity 2017 – available here
[2] Global Pensions Assets Study 2018 – available here

The most appropriate measure of the long-term performance of venture capital and private equity is on a since-inception basis, and under this metric, our latest performance measurement survey shows that UK funds continue to demonstrate a high level of persistence and consistency in performance, with returns tending to hover in a band of approximately 15% over the past decade[3]. To complement our performance measurement survey, there is US research that shows how allocations to private assets can improve investment performance:

- Data from US endowments and foundations provided to Cambridge Associates LLC[4] ("**Cambridge**") showed that portfolios with more than 15% allocated to private investments have outperformed their peers consistently, and for decades. Cambridge attributed the outperformance to venture capital, private equity, and distressed securities far outperforming public asset classes, earning annualised returns of 12.5%, 11.9%, and 10.8% respectively over the last 10 years.

- Analysis performed in 2013 by Willis Towers Watson[5] looked at the asset allocations of a subset of large plan sponsors for 2010 and 2011, comparing DB and DC plan performance to simulated investment returns. Using an asset-weighted measure of returns, DB plans outperformed DC plans by an annual average of 76 basis points from 1995 to 2011. The report noted that DB plan sponsors have been replacing equities with more fixed-income and alternative investments to diversify their investment portfolios and better match assets to liabilities.

The non-use of alternatives including illiquid assets constituting patient capital, and its consequences, are clearly evidenced in the pensions sector as explained above. These comments can also be applied more broadly to non-pensions funds. Accordingly, and for the reasons noted in our responses below, we consider that alleviating restrictions or creating an entirely new category of investment vehicle to which none of the restrictions that apply to authorised funds apply would be an important part of the overall solution to facilitate investment in patient capital, including venture capital and private equity.

Questions

Q1: Do the category limits strike the right balance between enabling retail investments in patient capital while ensuring investors can redeem their investments in a timely fashion? If not, what changes should be made to existing structures?

We do not consider that the category limits strike the right balance between enabling retail investments in private assets constituting patient capital while ensuring investors can redeem their investments in a timely fashion. A UCITS scheme is generally not suitable as an investment vehicle with a core strategy of investing in private assets. In particular, a UCITS scheme may not invest more than 10% of the scheme property in transferable securities that are not admitted to, or dealt in, on an eligible market; and may not invest more than 30% of its value in non-UCITS collective investment schemes (and even then, the non-UCITS schemes must be NURS or equivalent). Other investment restrictions, for instance in relation to the valuation and transferability of investments, the use of derivatives, and borrowing restrictions, may be problematic. There are also restrictions

[3] BVCA Performance Measurement Survey 2017 – available here
[4] The 15% Frontier, July 2016 - available here
[5] Insider, May 2013 – available here

on investing in patient capital that apply to NURS and QIS, which we address in our responses to Q2 and Q4 - Q6 below.

Q2: Is there retail investor demand for a new type of authorised retail fund which can, for example, invest all its capital directly into patient capital assets?

We understand from our members that there is demand for such a vehicle, however, we believe that restrictive product regulation operates today as an effective barrier to the demand for investment by DC schemes in private assets. For the reasons noted in our responses to Q4, Q5 and Q6, we do not consider current authorised fund structures to be suitable, rather the solution is to alleviate the restrictions or create a new category of investment vehicle to which these restrictions would not apply in order to facilitate wider access to patient capital.

Q3: If authorised funds marketed to retail investors were permitted to hold more patient capital, what safeguards do you think are needed to adequately protect investors?

Safeguards would have to be introduced to ensure that retail investors were aware of the nature of the risks involved. This would include the use of appropriate risk warnings in fund documentation. Further restrictions may include requiring funds that invest in patient capital and illiquid assets only to admit retail investors on an advised basis.

We would like also to highlight the distinction between: (a) marketing directly to retail investors; and (b) marketing to insurance companies that write insurance policies for retail clients (policyholders) under linked long-term contracts. In scenario (b), private equity and venture capital funds would be marketing to the insurance company, which is a professional investor even if the policyholder is exposed to the risks of the performance of the fund. The challenge would be for the insurance company to disclose to its policyholders the risks associated with illiquid investments (which is precisely what DP 18/40 contemplates).

Q4: Should NURS have a broader ability to finance infrastructure projects than is currently possible under our regime? If so, what changes do you think are necessary to our handbook?

A NURS is currently not suitable as an investment vehicle with a core strategy of investing in private assets including, but not limited to, infrastructure projects. The restrictions that apply to NURS similarly impact investment in private equity.

In particular, a NURS scheme may not invest more than 20% of the scheme property in transferable securities which are not admitted to or dealt in on an eligible market; and may not invest more than 20% of its value in collective investment schemes which are not UCITS, NURS or equivalent, unless it is established as a NURS fund of alternative investment funds ("**FAIF**"). The 20% buckets are unhelpful for investment vehicles with a core strategy of investing in private assets and consequently limit investor choice.

Moreover, a NURS may only invest in unregulated schemes (even if it is established as a FAIF) if the participants in such schemes are entitled to have their units redeemed at net asset value. This, therefore, precludes any investment at all by a NURS in any closed-ended funds, including where the NURS is itself a fund of funds which would by nature be more diversified, and have a lower risk profile, than a NURS holding patient capital directly.

Other investment restrictions, for instance in relation to the due diligence requirements, valuation and transferability of investments, the use of derivatives, and borrowing restrictions, may be problematic. We consider that creating an entirely new category of investment vehicle to which none of these restrictions apply could be an important part of the overall solution to facilitate investment in patient capital rather than applying changes to all NURS.

Q5: Do the current rules governing QISs provide professional and sophisticated retail investors with sufficient access to patient capital? If not, why not and what changes do you think are necessary to our handbook? If our rules do not provide sufficient access for QISs to fund patient capital please suggest which handbook changes could be changed to address this.

A QIS does not impose the same percentage limitations as described above on investments in unquoted equities. A QIS could, therefore, provide a viable solution for a private equity fund investing directly in unquoted securities. Similarly, for funds of funds (structured as a QIS), there is more flexibility in percentage terms with respect to investments in unregulated collective investment schemes. However, for managers of funds of funds, there are onerous due diligence requirements for the manager to undertake in relation to the target portfolio fund, both pre-investment and on an on-going basis. Guidance on this is detailed and may not be practical to follow, especially in context of, say, secondary fund acquisitions (where access to the underlying portfolio fund manager may be restricted). In particular, many of the due diligence requirements seem duplicative in relation to an existing EEA Alternative Investment Fund managed by a full-scope EEA Alternative Investment Fund Manager. We also observe that there is a general lack of familiarity with the QIS model as the NURS is more commonly used in the market.

Q6: If QISs are permitted to hold more patient capital, what safeguards do you think are needed to adequately protect investors?

Please see our response to Q3 in relation to retail investors. We do not consider that any additional protections are required for professional / sophisticated investors.

Q7: Do the current diversification rules strike the right balance between investor protection, by requiring a prudent spread of risk, and sufficient access to patient capital? If not, do we need a different or more flexible approach to diversification rules? Please provide an explanation of your answer.

The current diversification rules do not provide for sufficient access to patient capital. In particular, where there has been an inadvertent breach, the time horizon for correcting a breach where a private asset is held will be longer than the six-month window contained in the current rules due to more complex process of divesting of an illiquid asset. A more flexible approach to the diversification rules should, therefore, be adopted to facilitate investment in patient capital.

Q8: If authorised funds' scope to invest directly into patient capital assets other than immovables is increased do we need a remedy similar to the proposed mandatory suspension to avoid investors being treated unfairly? If you agree that suspension rules would be appropriate, please set out your suggestions as to what such a remedy would look like. If you do not think suspension rules would be appropriate, please explain why not.

While we acknowledge that a mandatory suspension for funds investing in immovables will be a helpful mechanism for authorised fund managers, we note that the proposal in large part arose in response to the specific risks in relation to property funds following the outcome of the UK referendum in 2016. In our view, there is a risk that extending the mandatory suspension provisions wholesale immediately may cause inadvertent risk of harm to investors, who may be overly restricted in their ability to take out their investment. We also note that the mandatory suspension proposal relies on a standardised valuation method (the Red Book), but for other illiquid assets and patient capital there may not be the same kind of pre-existing system of valuation which can be relied on.

Q9: Why do you think the specialised funds have not being used in significant volumes?

We agree that such specialised funds have not been used in significant volumes. Such funds often have relatively high minimum investment criteria, for example, for EuVECAs this is EUR 100,000. Moreover, ELTIFs require a minimum investment of €10,000. This must also represent a maximum of 10% of the investor's total assets. ELTIFs are also unsuitable for fund-of-fund vehicles, as investments in other funds are not eligible investments; also, ELTIFs carry onerous operating / administrative requirements which limit their usefulness to managers and investors. Such criteria restrict the availability of these specialised funds for retail investors.

Q10: Are there specific features of these funds which prevent fund managers or investors from using them to invest in UK patient capital?

Please refer to our response to Q9.

Q11: Are there other areas where the current regulatory framework creates unnecessary barriers, either directly or indirectly, to investing into patient capital?

We welcome the FCA's work on permitted links rules and have responded to the FCA's Consultation Paper (CP18/40) on the proposed amendment of COBS 21.3 permitted links rules. Permitted links include unlisted securities, but the liquidity requirements (securities must be realisable in the short term) act as an effective barrier to investment in this asset class.

We consider that innovation from the new generation of platforms and DC providers should be embraced, including looking at the approach taken in other countries. As discussed above, one solution is to create a new fund vehicle that gives investors the structure they need to invest into illiquid asset classes.

We also welcome the forthcoming guidance from The Pensions Regulator on investing in illiquid assets, along with other initiatives to improve trustee training and guides with case studies on how pension funds invest in venture, growth and lower mid-market funds. Such initiatives should help to demystify what it means to invest in the asset class and help trustees to understand returns and costs entailed. The BVCA has also been a key contributor to the work of the FCA's Institutional Disclosure Working Group and its successor that will provide guidance and templates for capturing fee and cost information.

As more money has flowed into DC schemes, fund managers have adopted default investment options for the members. Defaults have many of the characteristics of a DB fund insofar as they

are managed by professionals and invest across a range of asset classes over the long-term, with specific targets in mind. In the US, default options can be very large and highly customised to meet the specific needs of the sponsor's workforce. This bespoke approach facilitates investments in alternatives, which can be mingled with other liquid asset classes so that they are sheltered from the individual participants' contributions and withdrawals. Therefore, the challenges around original investment, fees, regular pricing and liquidity are not insurmountable with careful portfolio construction and planning.

We also note that the structure of any default funds held in an automatic enrolment pension plan must be such that member-borne administration charges are no greater than 0.75% of the member's rights over a 12-month period. The cap means that higher fees/charges on private asset investments must be counterbalanced by lower charging investments in a default fund. However, the nature of private equity funds (including the carried interest model, whereby carried interest payments are potentially unlimited in amount, albeit typically only paid after the fund has returned investors' capital plus a preferred return) causes some DC schemes to be cautious about this area. We note that the Department for Work and Pensions is consulting on the consideration of illiquid assets and the development of scale in occupational DC schemes including the charge cap. We welcome this consultation.

We would be happy to discuss the contents of this letter with you; please contact Tom Taylor (ttaylor@bvca.co.uk).

Yours faithfully,

Tim Lewis
Chair, BVCA Regulatory Committee