EXHIBIT J

CUTTING THE GORDIAN KNOT: LONG-TAIL CLAIMS IN INSURANCE INSOLVENCIES

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CUTTING THE GORDIAN KNOT: LONG-TAIL CLAIMS IN INSURANCE INSOLVENCIES

The collapse of an insurer can be disastrous for its policyholders and others who rely on its promises. This article suggests, however, that the effects of insurer insolvency have been exacerbated in recent years by a misinterpretation of applicable law and a reluctance to employ technology widely in use in the solvent industry.

I. THE LIQUIDATOR'S DILEMMA

In 1984 when the first of what would prove to be a deluge of major insurance failures became apparent, few would have predicted that the liquidations of these companies would still be under way fifteen years later, and that the policyholders and claimants would not only be unpaid but unable even to predict when and how much they would be paid. Yet that is the case. Today, as the liquidations of Mission, Integrity, Pine Top, Ideal Mutual, Union Indemnity, Holland-America, and Transit approach their fifteenth anniversaries, only Transit has actually paid a dividend to policyholder creditors, and that is a partial one. [1] The insurance insolvencies of the middle 1980s were unusually large and complex, but in truth their longevity is not unusual. A twenty-year lifespan for the liquidation of a property/casualty insurer is not uncommon. [2]

***168** The principal legitimate reason for the longevity of insurance receiverships is the nature of the companies' obligations and assets. IBNR liability, the company's predictable liability for claims that have been incurred but not yet reported, or whose severity is insufficiently known, is increasingly recognized as a significant component of a property/casualty insurer's financial prospects. The development of some elegant statistical techniques, together with the assembly of increasingly massive databases of loss development statistics, have permitted regulatory and accounting authorities to demand that all insurers make provision for the probable development of unidentified, but nevertheless real, future liabilities. [3]

Chart 1 shows the payment pattern for a typical block of automobile liability insurance. This type of coverage is considered to possess a relatively short "tail," the time lag between the expiration of a policy and the date by which all claims can be expected to be concluded. Although, by a year after expiration, most potential losses have been identified and reserved for, less than half have been settled. Thirty percent of losses typically remain unsettled at the two-year mark, and almost 5 percent are still outstanding at five years. [4]

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***169** Chart 2 contains similar information for medical malpractice insurance, which possesses a longer "tail." Only 20 percent of ultimate liability on such policies is recognized by the first year; a minuscule amount of liability is settled by that time. Although half of the ultimate liability has been reserved for by the end of the second year, only about 10 percent of it has been paid. At the five-year mark, the figures are 85 percent and 66 percent, respectively. Even at ten years, a small fraction of ultimate liability is completely unrecognized by the insurer's reserves, and 10 percent has still not yet been settled.

Commercial general liability, product liability, and excess of loss insurance possess even longer "tails," in which as much as half of ultimate liability remains unrecognized at the fifteen-year point and unpaid at twenty years. The extraordinary circumstances created by long-simmering latent product defect, asbestos, and pollution claims mean that commercial liability policies written before 1979 may have tails that are fifty years long or even longer.

Historically, insurance liquidation orders have required claimants against the company to file their claims with the liquidator within a year or eighteen months after the order is entered. Many such orders require that the claim filing contain all evidence necessary to establish the insurer's liability. Not so long ago, it was possible to contend that any claimant who could not liquidate his claim in that time must have slept on his rights. However, the IBNR statistics demonstrate that ***170** such a contention is too harsh. Significant, and sometimes very significant, portions of an insolvent insurer's ultimate liabilities are owing to policyholders who cannot, by any form of diligence, quantify their claims in the traditionally allotted time.

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The problem of the "tail" is not limited to the liability side of the liquidation balance sheet. Many insurers purchase reinsurance, which obliges a reinsurer to reimburse the insurer for specified losses. Because longer-tail, higher-limits claims tend to be more heavily reinsured, potential reinsurance recoveries often make up a substantial component of an insolvent insurer's potential assets. Such recoveries are general assets of the estate; they are not traceable by the claimants whose claims produced them. Depending on the reinsurance and the amount of other assets available for distribution, it is entirely possible that the allowance of a late-developing claim may bring in more assets to the estate in the form of reinsurance recoveries than it costs in additional dividends. Thus, a premature claims cutoff not only deprives policyholders of valuable rights and allows windfall release from liability to reinsurers, it may actually reduce the pro rata share of all claimants, early and late alike.

On the other hand, lengthy extensions of the claims bar date are not a much better idea. It is dangerous to commence the distribution of estate assets until all claimants are identified and all amounts fixed. Nevertheless, claimants with pressing, already liquidated claims assert with perfect justice that they should not be required to wait indefinitely to protect the interests of nameless future claimants. Moreover, holding an estate open to accommodate long-tail claims causes increased administrative costs as well.

A principal objective of any insolvency proceeding is to allocate the insufficient assets of the insolvent entity ratably among its creditors, while causing as little collateral damage as possible. Applying this concept to the specific case of insurer insolvency, the objective of the insurance liquidator ought to be to collect and distribute the assets of the insolvent company in a way that preserves as much as possible of the economic and noneconomic features of the insurance promise. Key features of that promise include not only the obligation to pay the amount promised, but to pay it at the right time. Perhaps the most poignant of the problems exposed by recent insurance liquidation history is the inconsistent and unproductive way in which the law has dealt with contingency and delayed claims development. It is less clear, but worth considering, just how we could have done better to solve this liquidator's dilemma.

II. TYPES OF UNCERTAINTY IN INSURANCE CLAIMS

The handling of claims whose value is unsettled is a common feature of most insolvency procedures, [5] but it is particularly important in insurance insolvencies ***171** because protection against uncertainty is the essence of the insurance promise, and thus, claims subject to some sort of contingency are the largest category of an insolvent insurer's liabilities.

Contingency suffers from difficulties in definition. An insurance company faces many different levels of contingency. For instance, on the day it sold an insurance policy against liability and collected a year's premium, it would incur a noncontingent obligation to provide "coverage," but would expose itself to considerable uncertainty nonetheless. If, the next day, it repudiated

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that obligation, the policyholder would have no difficulty bringing an action for breach of contract, but damages would be problematical, because while the policy is not contingent, it would at that stage be uncertain whether an event leading to an insured loss would have occurred. Unless the disappointed policyholder could point to specific losses incurred during the erstwhile policy period, recovery would probably be for "cover," the cost of obtaining similar protection elsewhere. Alternatively, however, the policyholder might wait until the end of the policy period and use evidence of what losses actually occurred during that period as evidence of the value of the coverage promise. Once a breach is established, the choice of damage measures in conventional contract cases is usually up to the plaintiff to make. [6]

At the end of the policy term, a liability insurance policy written on an occurrence basis still has value to the policyholder in two instances. The first is when there were claims made during the policy period that have not yet been resolved. The events giving rise to liability (e.g., the policyholder's ostensibly tortious acts) have occurred, but the consequences of those events are in dispute. The insurer, likewise, may be uncertain whether it will have to pay a claim, although the facts on which the claim is based are amenable to determination. It is sometimes said that the insurer's liability is "contingent" at this stage, but this assumes that the qualification of liability through verdict or settlement is fortuitous. In fact, the liability of the insurer like the liability of the insured is unliquidated but not contingent from the date the events giving rise to liability occur.

The second instance is where it is possible that claims will be made after the expiration date based on events that occurred before it. The policyholder's right to protection against these unknown claims and his or her right to damages if they are denied are not "contingent" either, but they are distinctly unliquidated.

III. STATUTORY AND LEGAL FRAMEWORK FOR VALUATION OF CLAIMS

At least as long ago as the middle of the last century courts recognized that the owners of policies issued by insolvent insurers possessed cognizable claims against their assets even though, at the date of liquidation, some uncertainty attached to ***172** them. [7] The liability of the insurer commences when it obligates itself on the insurance policy, not when a claim becomes payable. As a result, policyholders possess noncontingent rights against the company. In normal course, the terms of their policy would control when any particular claim became payable. Thus, for instance, a claim against a surety could not be maintained until the principal debtor had defaulted, and a claim on a life insurance policy until the insured had died. But by becoming insolvent and going into liquidation, an insurer unilaterally terminates its obligations and breaches its contracts, and its policyholders immediately become entitled to damages for its breach of contract. [8] No less an authority than the U.S. Supreme Court has ruled that

> [By going into liquidation] the company becomes *civiliter mortuus,* its business is brought to an absolute end, and the policy-holders become creditors to an amount equal to the equitable value of their respective policies, and entitled to participate *pro rata* in its assets.... [9]

That a liquidating court cannot do equity among the parties at interest without recognizing the immature claims of policyholders was explained in *Commissioner of Insurance v. Massachusetts Accident Company:* [10]

> [I]t would seem that a large, if not the largest, interest in almost any insurance company must be that of policyholders who have not yet suffered loss, and that the solvency of the company and whether it should be allowed to continue in business should depend upon its probable ability to meet the future claims of such policyholders. It would be an anomaly if an adjudication of insolvency should itself have the effect of restoring the company to a sort of solvency through the immediate elimination of one of the principal blocks of its business.

Having recognized the rule, courts have not always been successful in applying it in ways that preserved the policyholder's economic interest. For instance, in *Newman v. Hatfield Wire & Cable,* [11] the New Jersey court, after explaining that "the uniform current of authority ... is to the effect that, as unmatured claims are provable against the bankrupt's estate, they are necessarily the subject of setoff," refused to allow a policyholder to set off against the liquidator's demand for workers' compensation premium his probable loss on pending workers' compensation claims, because they were "incapable of being ascertained definitely by arithmetical calculation." ***173** *Kipp v. Fidelity Title & Mortgage Guaranty Co.* [12] is another example. In that case, the court, having dealt easily with the allowance of claims that were immature at the date of liquidation if they had been established by the distribution date, punted on the claims of policyholders whose rights remained stubbornly unliquidated. Two reasons are implied: the assumption that those claimants had delayed acting on their rights ("[t]here has been ample time for contingent creditors to establish their claims") and the lack of any plausible alternative ("[t]he holder of a contingent claim cannot demand that the liquidation of the estate be delayed for his benefit, merely because of his possible future debt").

On the other hand, when courts were presented with viable alternatives, they rarely had difficulty allocating a share of the assets of the insolvent company's assets to owners of "possible future claims." For instance, courts given sufficient information to permit them to assign a value to immature insurance rights have readily accepted valuations based on the cost of replacement insurance coverage. [13]

In interpreting these cases, it is important to keep track of a distinction that the courts themselves frequently apply but rarely recognize: it is one thing to recognize a value that is ascertainable when the liquidation occurs, such as the cost of hypothetical replacement coverage; it is another to apply a value that takes into account evidence that can only be acquired after the date of liquidation, such as the amount of the policyholder's actual loss on a liability claim. Courts that recognize that policyholders own noncontingent rights against the company are invariably thinking in terms of valuation techniques that can be applied at liquidation or within a definite period thereafter. Courts that balk at allowing "contingent" or "speculative" claims have usually been presented with the policyholder's demand that the distribution of the assets of the estate be delayed so that the policyholder can finally ascertain the amount of anticipated losses.

It will be noted that the cases cited in this article predate the development of specialized statutes governing the liquidation of insurers. Cases decided under these specialized statutes require special consideration. In general, the components of a "modern" liquidation statute are three:

(1) a statement that the rights and liabilities of the insolvent company and its creditors are "fixed" as of the date of the liquidation order;

(2) a provision for a "bar date" by which claims must be filed in order to fully share in the assets of the estate; and

(3) frequently, although not universally, a "contingent claims" provision that often has two pieces: (a) a statement that, in order to share in the assets of the estate, "contingent" claims must be "determined" by a certain date, and (b) a provision permitting persons having claims against insured individuals (referred to as "contingent claims" in many statutes) to submit their claims directly to the ***174** liquidator, who is to allow them if it appears likely that the insured would otherwise suffer an insured-against loss on them.

The Wisconsin Insurers Liquidation Act, which was the basis of the NAIC Insurers Rehabilitation and Liquidation Model Act and thus of the liquidation laws in effect in most states, contains annotations by Spencer Kimball, who was largely responsible for its drafting. The annotation to section 645.63 is especially interesting:

> This section handles the traditionally difficult and mishandled problem of contingent claims....

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> The word "contingent" is often misused in the statutes. A true "contingent" claim is one where the event on which liability would arise has not yet occurred. An illustration is a possible future claim on a fire policy where there has not yet been a fire.... Many states bar all contingent claims. There is little justification for excluding them altogether, though there is reason to give them less favorable treatment, since they are not even claims at the time the rights of the parties are fixed. However, such claims rest on promises made by the insurer or its agents and should rank ahead of ownership claims, if the insurer has a surplus.
>
> Several categories of claims occasionally referred to as contingent claims deserve even better treatment. First, the claim of a third party who has not reduced his claim against the policyholder to judgment is only technically and superficially contingent, if contingent at all, and should be treated as if it were an ordinary claim. This technical contingency conceals the underlying reality of present insurer liability.... Second, unliquidated or undetermined claims are often miscalled "contingent" claims in the statutes, and either denied or relegated to an inferior place in the hierarchy of claims. This is unjustified, and perhaps has its historical origin in the misnaming of such claims as contingent. Unliquidated and undetermined claims should be regarded as absolute and unqualified claims. [14]

"Liquidation" or "determination" under the Wisconsin plan does not necessarily contemplate a proceeding outside the insolvency court. Insured and third-party claims, for instance, are "determined" when the liquidator recommends their fair value to the court. [15] Claims for the investment value of life insurance policies, or for unearned premiums, are "determined" even without the filing of claims when they are listed in the same court. [16]

Although the Wisconsin law became the template for the NAIC Model Act and, in turn, the liquidation laws of many states, the application of those statutes has been anomalous. In recent years conventional wisdom [17] has held that claims of insureds that have not yet been reduced to judgment or settled by agreement ***175** with the liquidator are "contingent." Contingent claims that are not liquidated within the prescribed time take no share of the insolvent estate. There is no room at all in this hierarchy for claims for the policyholder's "equitable value." This confluence of circumstances can leave the policyholder claimant in no-man's land and the estate in gridlock. Not surprisingly, the result predicted by the *Massachusetts Accident* court has begun to occur: companies are rendered ostensibly "solvent" in spite of earlier estimates of massive insolvency because a large component of their liabilities has been eliminated. [18] This apparent victory for the company is a defeat for the liquidation process and not coincidentally a windfall for any reinsurers exposed on the eliminated claims.

In an effort to avoid this unsatisfactory outcome while still concluding the liquidation in a reasonable amount of time, a number of liquidators have proposed schemes for the resolution of claims subject to uncertainty. They have been inconsistent in their approaches to the problem of contingency, and inconsistently successful as well.

IV. CLAIM VALUATION STRATEGIES

A. *Justice Bradley's Model and the "Gap"*

In 1889, Justice Bradley explained in *Carr v. Hamilton* [19] that: Every person's interest in a life insurance is capable of instant and present valuation, almost as certain and determinate as the discount of a note or bill payable in the future.... The value of each was easy of calculation by any competent actuary.

Bradley was dealing with life insurance policies, whose elements of uncertainty do not seem so daunting. Lesser minds than Bradley's, however, have not found this model so simple to apply. Although it is easy to accept the principle that any broken

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contract ought to have an "equitable value" that would be the measure of damages for its breach, not all such values are "capable of instant and present valuation," and that it is especially true when the contract is one for liability insurance.

Aside from the problems of measurement, however, Bradley's approach glosses over other difficult issues. The most vexing is the fact that, inevitably, there will be a lapse of time between the date as of which claims are measured and the date when the measurement is calculated. At what point is the liquidator entitled to cease processing new information? This problem is exemplified by *MacFarlane*, an English case. [20] The liquidators had established claim values based on returns of unearned premium as of the date of winding up. Since the company's policies ***176** chiefly covered property risks, that was a rough approximation of IBNR at the date of liquidation. Mrs. MacFarlane lost her house to fire during the time after the winding-up order and before her claim was evaluated, the "gap" period. She urged that her claim be allowed for the full value of her house, rather than merely for the unearned premium associated with her policy at the relevant date. The English court engaged in statistical wishful thinking, holding that the liquidator must take into account, in evaluating her policy, known events taking place after the claims bar date. Since claimants are unlikely to object to a valuation method that overstates their claims, the *MacFarlane* court's approach is virtually certain to inflate the total value of claims. The proprietors of English Schemes of Arrangement have been winking at the practical ramifications of this decision ever since, because it appears to say that it is never too late to submit additional information about such claims. [21]

It is submitted that the common sense approach to which both the *Carr* and *MacFarlane* courts were straining is this: a policyholder possesses a claim against the insolvent insurer on a simple breach of contract basis from the date it is liquidated, regardless of what happens next. But, as we have seen, the quantum of his or her claim is problematical. Conventional breach of contract damages would allow the policyholder to elect whether to pursue a replacement cost approach or to wait and see whether insured losses materialized. Insurance insolvency claimants expect the same right, but because it can take so long for insured claims to develop, the right cannot be unlimited. It is perfectly appropriate that actual loss development provide an alternative to replacement cost as a measure of damage, but it is equally appropriate to insist that after a certain date no further loss development information be considered, or else the liquidation will never finish. A claimant who is unable to "liquidate" his or her claim will nevertheless have a noncontingent claim for the equitable value of his or her policy, but the claimant must prove it on the basis of information available to the liquidator at the time of the bar date. Once the cutoff date is reached, the claimant cannot hold up the resolution of the rights of others to try to demonstrate that his or her own loss is greater than that predicted by actuarial estimates, nor may others try to prove the contrary.

B. *Replacement of Coverage Model*

Life insurance insolvencies have customarily been resolved by having solvent competitors assume both the assets and the liabilities of the troubled company, trusting to good management, the inherent conservatism of life reserving, and sometimes guaranty association support to eliminate the apparent shortfall. This is so obviously a beneficial arrangement for all concerned that, whenever it can be practically ***177** accomplished, it meets with little opposition. As a result, however, the legal grounds for these transactions are rarely analyzed.

A rescuing company assuming 100 percent of the insolvent's policies in exchange for all of its assets implicitly values the policies at an amount equal to or greater than the assets received. As long as all of the policies are assumed, there is not always a need to decide how much greater than the assets the policy values are. The equation becomes considerably more complicated, however, when not all of the policies are being assumed, or when only partial guaranty organization coverage is in effect.

An example of a replacement of coverage model is the plan put into place for Executive Life Insurance Co. (ELIC) in California. The plan employed the assets of the former company and additional contributions made by the affected insurance guaranty associations to fund replacement coverage offered by a new company. Policyholders who were not entitled to guaranty association coverage received a policy that provided a portion of the coverage promised by ELIC equivalent to the pro rata dividend that they would have received if the company had been liquidated conventionally. The legal sufficiency of the implicit

assumption that policyholders whose policies had not as of liquidation matured into present claims nevertheless had cognizable, noncontingent interests equal to the present value of their future claims was simply taken for granted in the extensive debate and litigation that surrounded the ELIC plan. In assessing the sufficiency of the valuations in controversy, however, the California Supreme Court seems to have assumed that what the policyholders could have obtained in liquidation was equivalent to the fair economic value of the policies and devoted its attention to whether the valuation techniques employed produced fair economic value. [22]

C. *Contract Damages Model*

The loss suffered by the owner of a policy issued by an insolvent insurer is essentially a loss caused by breach of contract, and it is quite feasible to apply a contract damages approach to claim valuation. If, for example, an insurer simply repudiated a particular policy (without becoming insolvent or subjecting itself to regulatory control), the policyholder could sue to recover damages. Those damages would be measured, as in any case of anticipatory breach of contract, by the present value of what the contract promised less the present value of what the policyholder would have to pay to obtain it, or, alternatively, the cost of obtaining the same benefit elsewhere. [23]

***178** In the liquidation of Inter-American Insurance Co. in Illinois, the liquidator proposed a valuation scheme premised on a present value calculation that employed an adjusted version of the company's own statutory reserve as a surrogate for present value. Reinsurance was a factor in Inter-American, and certain reinsurers did object to the proposed claim valuation. Their objections were overruled, and no appeal has (yet) been taken on the point.

D. *Cambridge Model*

The Bermuda liquidators of Cambridge Reinsurance undertook an early form of property casualty claims estimation. Cambridge presented an especially acute case of the liquidator's dilemma: it had written nothing but reinsurance; the majority of its assets consisted of reinsurance balances not yet owing; the plurality of its retrocessionaires had also ceded to it; retrocessionaires were reluctant to pay even presently due claims until they were assured that their own claims would be paid either in offset or in kind; and neither the ceded nor the assumed claims were expected to mature for twenty or thirty years. Cambridge's liquidator developed IBNR for each cedent based on a set of consistently applied standards. Reported reserves plus the developed IBNR were added to conventionally reported paid claims to produce a figure that was allowed by the liquidator in place of the claim each cedent would otherwise have. Retrocessions implied by the estimated claims were offset against the claims of each cedent, and dividends paid on the net amount. Retrocessionaires, in general, responded favorably to this treatment, and a considerable sum was collected in retrocessions. The estate was recently closed, having paid dividends well in excess of its initial estimate.

Cambridge makes a tantalizing model for property and casualty insurer liquidations, but it should be recognized that it benefitted from several unique advantages. It was entirely a reinsurance company. In contrast to claimants under direct property or casualty policies, the law of large numbers applied to Cambridge's claimants, each of which was virtually certain to have claims of some size, and could employ the same actuarial techniques as the liquidator to estimate their magnitude. Many of its reinsurers were also its creditors, and thus shared the interest of other creditors in salvaging whatever could be had from Cambridge's estate. The liquidators were unencumbered by restrictive legislation. Bermuda's law on the subject was vague enough to encompass almost any fair-minded scheme, especially with the approval of the creditors of the estate and its Committee of Inspection. Last, but not least, Cambridge's insolvency was so severe that claimants risked very little in accepting the estimation plan. By comparison to the prospect of receiving a small dividend far in the future, almost any solution looked attractive.

Pine Top, an Illinois company, is in the midst of a procedure along similar lines. Its liquidator has adopted a procedure for the estimation of assumed reinsurance claims that has survived test applications and is expected shortly to result in the allowance of specific assumed reinsurance claims. The Pine Top approach is based on claimants' own estimates of ultimate loss development (i.e., including not only ***179** case reserves but IBNR), evaluated on a case-by-case basis by the liquidator. Since most claims

are eventually agreed to, the result strongly resembles a commutation value. Pine Top has also substantial direct policyholder claims that have first priority against the assets of the estate, but it is thought that reasonable success in reinsurance collections will permit a significant dividend at the assumed reinsurance level as well. A single retrocessionaire unsuccessfully objected to the estimation procedure. How other retrocessionaires will respond to the impending cession of estimated claims remains to be seen.

Although it is attractively simple, the Cambridge/Pine Top model is difficult to defend when applied to individual insurance policies. Whereas the losses of reinsurance cedents are generally numerous, those of individual policyholders are usually not. As a result, most reinsurance cedents would have had at least some claims had their reinsurance continued to expiration; most policyholders would not have. Many policies will suffer no claims at all; an estimation plan like Cambridge's would pay them more money than they needed to pay claims. A few policyholders will suffer large claims; their dividend will be much too small to cover them. But a Cambridge-style dividend would still meet policyholder needs if it were paid quite soon after it was calculated (to minimize the "gap"), and if it were expended on the purchase of a further insurance policy covering, retroactively, all or part of what should have been covered by the insolvent company. Such an early resolution would be formidably difficult to accomplish, but if it opened the door to economical partial replacement coverage, it would be far and away the least costly and most effective means of protecting the policyholders' expectations.

E. *Rolling Dividends Model*

One way to avoid the issue of claim estimations while partially defeating the liquidator's dilemma was employed in the United States in American Mutual Reinsurance Co (AmReCo), and in the United Kingdom in the KWELM (Weavers) [24] insolvency. AmReCo has processed claims almost as if it were a solvent insurer, but has paid them partly in cash and partly with promissory notes payable only from the assets of the estate. The notes are paid as funds become available and the plan contains protective provisions should unexpected late claims development result in a determination that early noteholders had received more than their pro rata share of the eventual assets of the estate.

KWELM applied a similar approach to a creditor's book containing a substantial number of direct claims. Like AmReCo, it has employed estimates of ultimate claims divided by cash in hand to determine what could be paid on claims as they mature. As additional assets are recovered, owners of allowed claims are receiving ***180** additional dividends. Reinsurance is a significant factor for KWELM, and this approach minimizes the potential defenses that reinsurers might have to its ultimate claims. As with ELIC and Inter-American, KWELM has integrated guaranty organizations (the Policyholder's Protection Board (PPB)) into the process, and some claims can expect 90 percent payment more or less promptly after claim allowance. As in AmReCo, however, the dividend payment stream for nonguaranteed claims (and for the PPB) promises to be very long unless some further acceleration is attempted.

Although policyholder reaction to the KWELM scheme was largely favorable or passive, the scheme does illustrate some of the inevitable disadvantages of any insolvency plan that depends on the occurrence of actual third-party claims for claim valuation. Liability insurance usually promises not so much payment of claims after the policyholder has paid them as the assurance that, to the extent of the policy limits, the policyholder will not have to pay them or the costs of his or her legal defense at all. The promise of "cash on the barrel head" made available by an insurer is a strong settlement incentive, and the fact that the policyholder need not advance the money or suffer judgment for it is a good reason for him or her to buy more insurance. The KWELM scheme does little to protect these elements of economic value. Fortunately, most of the KWELM policies were coinsured with other, often solvent, carriers. To protect their own interests, these carriers have often financed defenses and negotiated settlements that the KWELM administrator will follow, reducing the instances of settlement gridlock that would otherwise occur. [25]

Another disadvantage inherent in the rolling dividend approaches like KWELM is caused by the inherent conservatism of fiduciaries. Even though all of these plans immunize the receiver against any surcharge should early distributions turn out to be excessive (and there is no real suggestion that such immunity would not be effective), receivers are reluctant to take any

chances with excess distribution. KWELM's administrators, for instance, set the dividend percentage at any given date on the basis of funds actually in hand, divide by claims ultimately expected to develop, and then build in a substantial "special margin" in case the claims exceed estimates. In effect, they are assuming that they will be unable to collect any reinsurance at all, but that claims will exceed estimates by a factor of 50 percent. As a result, the largest share of the money set aside to pay dividends in the last three years is still in the coffers of the estate. [26]

181 F. *Cutoff Model--Delta America Reinsurance

The simplest approach to long-tail liability claims in liquidation is probably the most common: to ignore any that arrive inconveniently late. An example is the closure plan for Delta America Reinsurance, which set a final, once-and-for-all bar date for the liquidation of claims and set out to distribute assets on those claims that met the deadline. There are certainly instances where this is an appropriate approach, in spite of the apparent violence to the rights of long-tail policyholders. For instance, Delta's policyholders were large ones and tended to have both known and IBNR exposures. Facing a limited pot of assets, they might well have concluded that their allocated share of assets would not improve if they, along with all other policyholders, were permitted to submit further loss development.

G. *Actuarial Estimation of Direct Claims*

Three recent opinions in the United States have dealt with plans to allow claims or to quantify reinsurance recoveries on the basis of actuarial estimates of ultimate loss development. The plans differed, as did judicial responses to them. None are completed. Unlike some of the other schemes described in this article, they have provoked organized reinsurer opposition, which continues.

1. Mission Insurance Company

In *Quackenbush v. Mission Insurance Co.*, [27] the California liquidator of Mission proposed a claims estimation plan "permitting him to estimate future IBNR losses for which Mission's reinsurers would be liable, although liability for, and the exact amount of, such losses remained undetermined." Mission's plan was curious in that it appears to have been the liquidator's intention to estimate claims, for reinsurance collection purposes, without actually allowing those same claimants to collect dividends based on their estimated claims. Citing statutory restrictions on allowance of "contingent" claims (that are not entirely on point), the California Court of Appeal rejected the plan.

This case has been described as holding that California law does not permit estimation. That is not quite true. A different result occurred when the liquidator proposed to actually allow policyholder claims and rank them for dividend by accelerated means. [28] There is no inherent reason why the "determination" of an uncertain claim must await the final resolution of the underlying litigation. On the contrary, both insurers and liquidators routinely settle claims by agreement, even though they are subject to some form of doubt, and there is no principled reason why a liquidator under the supervision of the liquidation court could not apply an estimation methodology that accomplished the same thing on a larger scale. The key flaw in the Mission liquidation plan was its insistence on creating reinsurance claims when the underlying insurance claim remained "undetermined."

***182 2. Holland-America**

The estimation plan approved for Holland-America Insurance, a Mission affiliate domiciled in Missouri, shows the impact of the actual allowance of claims on the estimation argument. [29] It was also influenced, however, by a different statutory regimen and a rather different judicial approach. In 1990, the Holland-America court had declared that "IBNR" claims would be provable in the liquidation if they were "readily ascertainable." A 1992 revision took advantage of the intervening adoption of a statute specifically allowing IBNR claims calculated by actuarial or other methods affording "reasonable certainty." A 1995 "final

dividend approach" employed claims constructed to include IBNR and contemplated collection of reinsurance on the IBNR claims. Reinsurers objected, somewhat belatedly, that IBNR claims were too "speculative" and thus should not be allowed. The Missouri court held that the necessary estimation was clearly within the implicit and statutory authority of the liquidator. Litigation continues over just how the estimation ought to be accomplished.

3. Integrity

The Missouri court had the advantage of a strong, albeit retroactively adopted, statutory framework. The scheme approved by the New Jersey court for the final distribution of Integrity Insurance Company's estate had to deal with an inflexible, if not hostile, statutory scheme. [30] New Jersey law allowed as fourth priority "claims by policyholders, beneficiaries and insurers arising from and within the coverage of and not in excess of the applicable limits of insurance policies and insurance contracts issued by the company...." However, it also provided that "no contingent claim shall share in a distribution of the assets of an insurer ... except that such claims shall be considered, if properly presented, and may be allowed to share where ... such claims become absolute against the insurer on or before the last day fixed for filing of proofs of claim." [31] A second provision established a separate procedure when a claim against an insured was presented by a third party. [32] Integrity's liquidation order had expressly preserved the rights of policyholders to file contingent and unliquidated claims, and numerous policyholders had done so. Since neither provision seemed to provide a means of disposing of these claims, the liquidator proposed instead to present claims *on behalf of* the unknown future claimants and to permit those claimants to share in the ultimate dividend paid.

Reinsurers, objecting to the proposed plan, asserted that "historically virtually all insurer insolvencies have been resolved on the basis of specific, individual claims for known, verifiable losses," and that such an approach was compelled by the New Jersey statute. [33] The trial court pointed out that the reinsurers' historical ***183** analysis was shortsighted, since there was in fact New Jersey precedent for the allowance of claims against insolvent insurers based on the replacement value of the lost coverages. [34] It also pointed to extensive Bankruptcy Code precedent encouraging the estimation of unliquidated claims. [35] In spite of the title company cases, which point out the noncontingent character of the policyholders' rights, the trial court seems to have maintained the assumption that what it was evaluating was a package of "contingent" claims. Lacking explicit statutory authority, the court relied on its "broad equitable power" to afford the "broadest possible protection" to the public and the various claimants and beneficiaries of the Integrity estate.

The trial court's analysis can be questioned. If the claims in question are, indeed, "contingent" within the meaning of New Jersey Revised Statutes § 17:30C-282, the statute would appear to require that they be made "absolute against the insurer." Just how that is supposed to happen when no individual claimant has been identified is hard to conceive.

Soon after this ruling, however, and from a quite unexpected direction, the New Jersey Supreme Court in *Credit Lyonnais* recently provided what may be the solution to this conundrum. [36] One of Integrity's liabilities was a credit guaranty policy securing the payment of certain bonds. The principal obligors had defaulted before liquidation, but the policy required only that Integrity pay each installment as it became due. The creditor insisted that the losses were "incurred" when it became clear that the debtor's default was permanent. On its face, this dispute has very little to do with the subject of this article. The New Jersey Supreme Court, however, undertook an analysis that cut the parties' Gordian knot, and at the same time opened the door to a resolution of the whole problem of unliquidated claims in insurance liquidation. [37]

The court ruled that on the date of liquidation Integrity breached its contract with every policyholder. As a result every policyholder owned a cause of action for damages, and each policyholder's damages were the cost of replacement insurance. [38] Where, as in *Caminetti v. Manierre,* the likelihood of loss was so high that the policyholder could obtain no replacement insurance, then the proper measure of damage was the present value of the expected loss. Nowhere in the entire opinion does the court discuss section 28a or 28b, apparently considering them irrelevant to the determination of a claim that was not, by its standards, "contingent," but merely unliquidated.

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***184** The *Credit Lyonnais* court unfortunately did not have to address the much more befuddling problems of long-tail liability claims, and it did not have to confront the probability that its approach would result in payment to people who had no claims and insufficient payment to people who did. It is impossible to read the *Credit Lyonnais* opinion, however, without being convinced that the court was thinking not just about the relatively simple case sub judice but also about the much more complex problems looming ahead of it.

V. REINSURANCE

At first blush, allowing ceded reinsurance concerns to dominate plans for the handling of claims is incongruous. The liquidator's first obligation is undoubtedly to creditors, and especially policyholders. At the same time, however, he or she succeeds to the cedent's obligation to treat reinsurers' interests in utmost good faith. In spite of the potential for abuse offered by the possibility of "liquidation leverage," the liquidators must not tolerate procedures that artificially inflate reinsurance claims. But it is their marshal assets, and since reinsurance can be a substantial asset, the liquidators should also not tolerate their artificial or accidental suppression. If reinsurance exists in a liquidation estate, there is no reinsurance-neutral liquidation scheme, and there is no choice of liquidation approaches in which reinsurance is not a factor.

It is commonly observed that liquidation both delays and deters claims substantiation and settlement. Even if it were not for the hostile and unfamiliar procedures, the liquidator's refusal or inability to participate in settlement and trial, and the disappearance of the insurance policy's ready cash flow, the simple fact that the policy now offers reduced payments and uncertain delivery would cause many rational insureds to decide to forgo claims. These forfeited claims are part of the invisible cost of insurer insolvency; each one represents an irretrievable failure of the insurance industry to keep its promises, but also a windfall to the reinsurers that might otherwise be charged with their claims.

Claims liquidation bar dates have one obvious effect on claims (the elimination of a whole class of them) and a less obvious one if liquidation leverage would have fattened the dividends of short-tail claimants with long-tail reinsurance recoveries. The reverse (that cutoff prevents dilution of the dividends received by early liquidated claimants) seems to be rare in practice. Either way, the effect on reinsurers is simple: liabilities decrease.

A claims estimation, however, could create an even bigger windfall for reinsurers if it were determined that the liquidator could not collect from reinsurers when claims were estimated that would otherwise have matured naturally. An accidental loss of reinsurance coverage is a prospect that rightly deters many liquidators from estimations. Reinsurers of integrity are loath to profit from their cedent's misfortune. Reinsurers of lesser mettle are not so foolish as to admit their motives.

Reinsurers have argued that one of the economic benefits of assuming risk is ***185** the chance that today's estimates of investment income and ultimate loss will prove pessimistic. They have the contractual right, they say, to play out the bet that they made that losses will not be as large as estimates, or that investment income will be greater. Whether the estimates are right or wrong, they have the right to use their claims money in the meantime. To alter the timing of their obligation would tip the balance of risk and burden that is the heart of reinsurance.

The argument begs a large question: Is unexpectedly early payment within or outside the range of outcomes whose risk the reinsurer assumed when it initialed the slip? Failing more pointed authority, we look to general principles of reinsurance and seek analogies in other situations.

The reinsurer's obligation to "follow the fortunes" of a cedent in dealing with reinsured claims is surprisingly difficult to pin down, although it seems to be at the heart of the reinsurance relationship. At least where the contract contains loss settlement language, and often when it does not, it is common ground that a reinsurer may not retry issues of fact or law incorporated in a good faith decision to settle a covered claim. [39] At the other extreme, there are payments made by cedents to which a reinsurer

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need not contribute such as extracontractual obligations and payments made to settle other insurance obligations. [40] Of course, the parties can and do agree to other limits by outright exclusions or through procedural filters such as notice requirements.

In contrast, reinsurance of settled coverage disputes vexes the courts that consider it. The argument that the reinsurer agreed to pay for claims the policy covers, but not for those it does not cover, has had a seductive attraction to judges and courts. American thinking tends to be influenced by a quotation from Justice Story in *New York State Marine Insurance Co. v. Protection Insurance Co.*:

> The consequence would seem to be, that, as no voluntary payment by the original insurers would be binding or obligatory upon the reassurers, they are compellable to resist the payment, and to require the proper proofs of loss from the assured in a regular suit against them, so as to protect themselves by a bona fide judgment to the amount of the recovery against them under their reassurance. It was to avoid this inconvenience and delay, as well as peril, that the French policies of reassurance ... usually contain a clause, allowing and authorizing the original insurers to make, *bona fide*, a voluntary settlement and adjustment of the loss, which shall be binding on the reassurers. This, of course, puts the whole matter within the exercise of the sound discretion of the party reassured, whether to contest, or to admit the claim of the first assured. But, independently of such a clause, it is clear, by the French law, that the original assurers must, in a suit brought by the reassurers, establish the same facts, as would entitle the assured to recover upon the original policy. [41]

***186** Appleman reads *New York State Marine* to stand for the proposition that "a reinsurer may make the same objections and raise the same defenses that the reinsured could in a suit on the primitive policy" and implies that the "French" clause and Story's 1841 reference to it support a view that, before being liable to the cedent, the reinsurer may demand that the cedent prove the insured's claim. [42] The actual language in use in the case before Story is not clear, but a survey of the historical context of his decision strongly suggests that what he referred to as the "French" approach is in fact the one in common use today so Story's opinion actually supports the opposite view.

The development of standard language in English and after *New York State Marine* is chronicled by a series of English cases that represent a determined effort in the London markets to find language that would adequately convey their intention to be bound to pay claims settled in good faith, giving up to one degree or another their right to second-guess claims judgments integral to their settlement with the original insured. In *Chippendale v. Holt*, [43] the Commercial Court held that the phrase "subject to the same terms and conditions as the original policy and to pay as may be paid thereof" was not "meant to create a liability outside the limits of the original policy."

A few years later, the term "pay as may be paid" was interpreted

> to require the reassured first to show that a loss of the kind reinsured has in fact happened; and, second, that the reassured has taken all proper and businesslike steps to have the amount of it fairly and carefully ascertained. So long as liability exists, the mere fact of some honest mistake having occurred in fixing the exact amount of it would afford no excuse for not paying. [44]

In other words, determining the extent of the loss was within the discretion of the insurer, while the existence of the insurer's liability itself could be challenged. But this, apparently, was not what the market wanted to hear. The trouble was that it prevented the cedent from dealing effectively with disputed questions of coverage. Participants kept trying new formulations of the reinsurer's liability in an attempt to make the contracts perform in court as the parties meant them to. What seemed to best express their intent was a clause requiring the reinsurer to "follow the [cedent's] settlements."

In *Excess Insurance Co., Ltd. v. Mathews,* Mr. Justice Branson effected a full retreat from *Chippendale* when a "follow settlements" clause was in effect:

> It was decided in *Chippendale v. Holt* that the words "to pay as may be paid" do not compel the reinsurers to pay where there was in fact no liability on the original policy.... The plaintiffs contend that the words "to follow their settlements" should be construed so as to carry the matter a step further and to bind the reinsurer by a ***187** compromise of the question of liability as he was already bound by a compromise of amount.... In my view the construction of the plaintiffs is correct. [45]

As Lord Justice Scutton explained in *Gurney v. Grimm,* [46] what underwriters were trying to accomplish was this:

> "We desire to reestablish the position which was accepted by a large number of people in the insurance world before the decision of *Chippendale v. Holt,* and we desire to have an insurance by which if we are satisfied that we ought either to compromise or to arrange ... you the reinsurers agree to relieve us of the responsibility of proving that there has been the loss mentioned in the original policy".... I think the original insurers were seeking, and the reinsuring companies knew they were seeking, a protection which would be available to them if they *bona fide,* in the first instance, resisted the claim ... and then were persuaded that it was right....

On closer inspection, the "French" language referred to by Story must have been the "follow settlements" language construed by the English courts and that now appears, with significant variations, in U.S. reinsurance treaties of every description. It is now so common in U.S. practice that it nearly caused the Ninth Circuit to forget the difference between fact and law. [47]

As the Ninth Circuit learned, however, reinsurance remains a fundamentally consensual business, and although many of its practices benefit from long-standing convention, they are not obligatory. Against the background of traditional, tested terminology, parties continue to tailor their undertakings to accommodate their own prejudices, habits, and needs. As the traditionally informal partnership between underwriter and reinsured has become more formalistic and sometimes hostile, reinsurers are not always prepared to bind themselves to follow the reinsured's settlements.

The House of Lords recently considered another approach. In *Hill v. M&G Reinsurance Co.,* [48] the follow settlements clause contained provisos that the settlements be "within the terms and conditions of the original policies ... and within the terms and conditions of this Reinsurance." The underlying insurance covered Kuwait Air Lines's airplanes for up to $300 million for "any one occurrence" during 1990 and 1991. The reinsurance was excess of loss reinsurance; moreover, it only applied to losses in 1990. Iraq appropriated seven KAC aircraft in 1990; in 1991 they were destroyed. The underlying claim was settled for $300 million, on the basis that there was one "occurrence" involving seven planes and that it occurred in 1990. A colorable argument could have been made that there were seven occurrences, none reaching the reinsurers' attachment point, and that they occurred in 1991. Having first pointed out that neither of these issues had to be ***188** determined to establish the underlying insurers' liability to KAC, [49] Lord Mustill went to the heart of the matter:

> There are only two rules, both obvious. First, that the reinsurer cannot be held liable unless the loss falls within the cover of the policy reinsured and within the cover created by the reinsurance. Second, that the parties are free to agree on ways of proving whether these requirements are satisfied. [50]

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Turning to the follow settlements clause, Mustill interpreted it as drawing a distinction between determinations of facts necessary to a determination of the underlying claims and legal conclusions regarding the extent of the coverage. The reinsurer was bound to follow the reinsured's settlements, except "where the settlement would bind the reinsurer to a definition of cover different from that which he has contracted to accept." [51] This contrasts sharply with Lord Justice Scutton's application of a follow settlements clause without the provisos in *Gurney v. Grimm*. [52] As Lord Mustill pointed out, one of the obvious rules is that "the parties are free to agree on ways of proving whether these requirements are satisfied." [53] The difference in outcomes between *Hill* and *Gurney* is simply a result of different agreements.

Hill is sometimes cited as a rejection of the follow the fortunes doctrine, but it is rather evidently no such thing. It does, however, affirm the right of the parties to a reinsurance contract to define which fortunes they will follow.

The furor over follow settlements clauses, however, masks some even more important common ground. When we speak of the reinsurer's agreement to "follow the fortunes," we are often referring to two discrete problems. On the one hand, we are talking about an obligation of the reinsurer to share the experience of the cedent when it makes what hindsight identifies as a "bad" settlement decision, as well as when it makes a fortuitously "good" one. That really is what "following settlements" is about, and the gravamen of the clause is that the actions in question are more or less voluntary.

But "follow the fortunes" has a second implication that is of considerably greater importance in ascertaining coverage of estimated claims in liquidations, and that does not appear to be open to debate. The "original risk principle" applies, as a matter of law, to any reinsurance, regardless of contract language, purely as an incident of the basic obligation of indemnity.

> The *original risk principle* includes neither thereinsured's commercial or investment risks nor post-loss claims adjustment actions. Rather, it is confined to the underwriting risk. It binds the reinsurer by the "fate" or "destiny" or "fortune" of the reinsured as regards the entirety of the fortuitous original risk of loss insured insofar as that risk ***189** has been reinsured. The reinsurer is thus bound along with its reinsured by whatever additional and unforeseen duties that a fortuitous pre-loss change-- *e.g.* in the risk, in the object insured, or in law as a result of judicial interpretation or legislative amendment--may impose upon the reinsured without the reinsured having done anything to bring about the change. [54]

In plain English, if an insurer insures against fortuitous events and a reinsurer undertakes to indemnify him or her against losses so incurred, the reinsurer is not entitled to refuse payment just because the loss that occurs is unexpected. Any number of surprising outcomes for the cedent are still reinsured. Utter bungling by the cedent leading to losses that "should not have happened," misguided settlements, legal malpractice, unprovable dishonesty by claimants, or cases of first impression are not excuses for nonpayment.

One of the most practical settlements of a serious coverage dispute is a policy buydown, but the transaction also pushes the envelope of a reinsurer's liability for payment. Unquestionably a reinsurer should participate in a return of premium when a policy is canceled by agreement. Must it also participate in a payment in lieu of disputed defense and indemnity costs? Case law exists on settlements made in bad faith or without required notice, and on unfair allocations of settlement costs that mistreat the reinsurer or overextend its exposure, but the pure issue seems rarely to have been raised in published case law. Arbitration history, necessarily incomplete, is no better. The issue is frequently threatened but rarely, if ever, raised. It can be seen from the previous discussion that the answer will depend to some extent on how the parties defined their obligations to each other. However, under the simple follow settlements clauses in common use before 1990, Lord Justice Scutton's working hypothesis still holds 100 years later: the reinsurer is obliged to pay "if the original insurer genuinely settles a genuine claim." If the cedent's business judgment or obligations demand settlement at an early stage, the reinsurer may not complain that the timing does not suit. But different language may compel a different result for voluntary settlement of a claim.

A claims estimation in liquidation shares characteristics of a policy buydown, but differs in one important feature: it is not a voluntary concession of liability, but a means of determining and liquidating a liability that, as we have seen, is already absolute as a matter of law. It is, in fact, a development of the "original risk" insured by the cedent, which the reinsurer is bound to follow. It may well be that the reinsurer's legitimate expectations regarding the timing and speculative character of future losses are frustrated by its cedent's insolvency, but the same misfortune has also occurred to the cedent, and indeed, to its policyholders. Protection against unforeseen developments is what indemnity is for.

*190 VI. CONCLUSION

It is submitted that, in light of the high utility of early estate resolution, an estimation program that compelled distributions to policyholders unlikely to ever have claims would still be worth the attempt. But the New Jersey court's analysis suggests a better solution. If it is the economic value of the policy that the policyholder has lost, then a dividend based on that value is perfectly fair.

The predicament of the liquidator confronted by long-tail claims and slowly maturing reinsurance is, in fact, recent and largely self-inflicted. Although statutes can, and undoubtedly should, be amended to clarify and improve the remedies available, law currently on the books clearly demands that the economic value of insurance policies be recognized in liquidation. Claims payment schemes that depend on such a recognition should not impair the collectibility of the insolvent company's reinsurance. It is submitted that it is the affirmative duty of the liquidator of any insurer seriously affected by long-tail claims to either initiate or accept determination of these unliquidated claims by actuarial or other methods offering a reasonable degree of certainty and accuracy.

Footnotes

a1 *Mary Cannon Veed is a partner at the firm of Peterson & Ross in Chicago.*

1 As of February 1996, Transit had distributed $120 million to creditors, whose claims are thought to total more than $4 billion. But its collected assets already total over $600 million. The remainder is being held to pay claims not yet settled. 7 MEALEY'S LITIG. REP.: INS. INSOLVENCY 17, at 11.

2 Illinois, which maintains an efficient and energetic receivership system, recently closed the estate of Market Insurance after sixteen years; it projects the closure of American Reserve, a major liquidation that commenced in 1979, this year. Pacific Mutual Life Insurance, which collapsed in California during the 1930s, was still in the courts in 1956. Pac. Mut. Life Ins. Co. v. McConnell, 44 Cal.2d 715, 285 P.2d 636 (1955).

3 Financial Accounting Standards Board FAS 60; National Association of Insurance Commissioners SSAP 45.

4 The source of the figures shown in this chart and the following one is an unpublished analysis, prepared by Milliman & Robertson, Inc., of the experience of principal underwriters in specific types of businesses, and is intended to be representative of the general experience of the industry.

5 *See, e.g.,* the handling of "contingent" claims estimation in the Bankruptcy Code, 11 U.S.C. § 502(c), and under previous law in First Empire Bank v. FDIC, 572 F.2d 1361 (9th Cir. 1978) and Maynard v. Elliott, 283 U.S. 273 (1931).

6 *See* U.C.C. §§ 2-712, 2-714.

7 Ingersoll v. Missouri Valley Life Ins. Co., 37 P.530 (D. Kan. 1889); Commonwealth v. Richardson, 94 S.W. 639 (Ky. 1906); Hoyt v. Hampe, 214 N.W. 718 (Iowa 1927); McDonnell v. Alabama Gold Life Ins. Co., 5 So. 120 (Ala. 1888); Evans v. Illinois Sur. Co., 298 Ill. 101, 131 N.E. 262; *In re* Empire State Sur. Co., 214 N.Y. 553, 108 N.E. 825; Newman v. Hatfield Wire & Cable, 174 A. 491 (N.J. 1934); Caminetti v. Manierre, 142 P.2d 741 (Cal. 1943).

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8 Smith v. National Credit Ins. Co., 68 N.W. 28 (Minn. 1896); *In re* Empire State Sur., 214 N.Y. 553, 108 N.E. 825; Boyd v. Wright, 96 S.E. 338 (Ga. 1918).

9 Carr v. Hamilton, 129 U.S. 252 (1889).

10 50 N.E.2d 801 (Mass. 1945).

11 174 A. 491 (N.J. 1934).

12 174 A. 229 (N.J. 1934)

13 American Lead Pencil Co. v. N.J. Title Guar. & Trust Co., 130 N.J. Eq. 148, 151 (Ch. 1941); Davis v. Amro Grotto M.O.V.P.E.R., Inc., 89 S.W.2d 754 (Tenn. 1936); Caminetti v. Manierre, 142 P.2d 741 (Cal. 1943); Universal Life Ins. Co. v. Binford, 76 Va. 103 (1882).

14 WISC. STAT. § 645.63, "Special Claims."

15 WISC. STAT. § 645.64(3).

16 WISC. STAT. § 645.71.

17 The term is used advisedly. There is little, if any, actual case law that directly supports the contention that policyholders who assert breach of contract-type claims for the equitable value of their policies are excluded from either the estate or from policyholder priority status. As explained here, those cases that appear to hold that so-called contingent claims are not allowable in fact turn on failures of proof.

18 Mutual Fire Marine and Inland Insurance Co. recently emerged from rehabilitation proceedings having paid all claims allowed against it. Unfortunately, the rehabilitation plan that made this possible eliminated many valid claims and discouraged the prosecution of others. 8 MEALEY'S LITIG. REP.: INS. INSOLVENCY 15, at 5.

19 129 U.S. 252 (1889).

20 *In re* Northern Counties of England Fire Ins. Co., MacFarlane's Claim, 17 Ch.D. 337 (1880).

21 Actually, the English law is considerably more nuanced, or at least inconsistent. *See* Ellis & Co.'s Trustee v. Dixon-Johnson, 1924(1) Ch.D. 342 at 357, and *In re* The Albert Life Insurance Co. 9 L.R.Eq. 716 (1870).

22 Commercial Nat'l Bank in Schreveport v. Superior Court, 17 Cal. Rptr. 2d 884 (Cal. App. 1993).

23 In addition, a breach of contract claimant might obtain consequential or even punitive damages, but if the claimant is entitled to such damages against an insolvent insurer, he or she probably is not entitled to receive the same priority of payment for them as if they were claims directly under the policy. Payment of general creditor claims in an insurance liquidation is sufficiently rare that few insureds bother with consequential damage claims.

24 KWELM is a proceeding for a "scheme of arrangement," akin to a U.S. Chapter 11 plan, for a cluster of companies that jointly underwrote insurance in the London Companies Market as part of what was known as the H.S. Weavers line slip. They are Walbrook Insurance Co., Kingscroft Insurance Co., El Paso Insurance Co., Lime Street Insurance Co. of the United Kingdom, and Mutual Reinsurance Co. of Bermuda.

25 A related disadvantage is the inability of the erstwhile insured to purchase replacement coverage. KWELM policyholders are neither insured nor uninsured, but caught in a curious limbo.

26 This phenomenon also accounts for the fact that roughly two-thirds of the money set aside for dividends in Transit is still unpaid. The Interstate Insurance Receivership Compact's proposed Uniform Receivership Law explicitly immunizes receivers that pay what turn out to be improvident early dividends against liability to later claimants, but whether that will induce greater daring in distribution of assets remains to be seen.

27 54 Cal. Rptr. 2d 112 (Cal. App. 1996).

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28 73 Cal. Rptr. 2d 95 (Cal. App. 1998).

29 8 MEALEY'S LITIG. REP.: INS. INSOLVENCY 12 (Nov. 13, 1996).

30 8 MEALEY'S LITIG. REP.: INS. INSOLVENCY 13, at 4 (Dec. 2, 1996).

31 N.J. STAT. ANN. § 17:30C-28a (West 19____).

32 N.J. REV. STAT. § 17:30C-28b (19____).

33 N.J. REV. STAT. § 17:30C-28a (19____).

34 *In re* Citizens Title & Mortgage Co., 127 N.J. Eq. 551 (Ch. 1940); American Lead Pencil Co. v. N.J. Title Guar. & Trust Co., 130 N.J. Eq. 148 (Ch. 1941).

35 *In re* Ford, 967 F.2d 1047 (5th Cir. 1992).

36 *In re* Liquidation of Integrity Ins. Co. (Credit Lyonnais), 657 A.2d 902 (N.J. Super. 1995).

37 The decision is somewhat remarkable because the approach taken is sua sponte. The court's approach is entirely independent from the arguments of the parties, and is only suggested by the decision of the court below.

38 *Citing* Caminetti v. Manierre, 142 P.2d 741 (Cal. 1943); Carr v. Hamilton, 129 U.S. 252 (1889); and Commissioner of Insurance v. Massachusetts Accident Co., 50 N.E.2d 801 (Mass. 1945).

39 Royal Ins. Co. v. Caledonian Ins. Co., 187 P. 748 (Cal. 1920).

40 Independence Ins. Co. v. Republic Nat'l Life Ins. Co., 447 S.W.2d 462 (Tex. 1969); Michigan Millers Mut. Ins. Co. v. North Am. Reins. Corp., 452 N.W.2d 841 (Mich. App. 1990); American Ins. Co. v. North Am. Co. for Property and Cas. Ins., 697 F.2d 79 (2d Cir. 1982).

41 New York State Marine Ins. Co. v. Protection Ins. Co., 18 Fed. Cas. 161 (D. Mass. 1841).

42 13A JOHN A. APPLEMAN, INSURANCE LAW AND PRACTICE § 7693 (1976).

43 1 Com. Cas. 197 (1895).

44 Western Assurance Co. of Toronto v. Poole, 1 KB 376 (1903).

45 23 Lloyd's Rep. 71, 65-76 (1925).

46 44 Lloyd's Rep. 189 (1932).

47 National Am. Ins. Co. of Cal. v. Certain Underwriters at Lloyd's, 93 F.3d 529 (9th Cir. 1996).

48 3 All E.R. 865 (1996).

49 *Id.* at 871.

50 *Id.* at 878.

51 *Id.* at 880.

52 44 Lloyd's Rep. 189 (1932).

53 3 All E.R. 865, 878 (1996).

54 William Hoffman, *Common Law of Reinsurance Loss Settlement Clauses: A Comparative Analysis of the Judicial Rule Enforcing the Reinsurer's Contractual Obligation to Indemnify the Reinsured for Settlements*, 28 TORT & INS. L.J. 659, 666 n.25 (1993).

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