

In the Matter of the Rehabilitation of:

Segregated Account of
Ambac Assurance Corporation

Case No. 10 CV 1576

**CAPCO'S BRIEF IN SUPPORT OF ITS OBJECTION TO
THE PROPOSED PLAN OF REHABILITATION**

The Consumer Asset Protection Company ("CAPCO") submits this brief in support of its Objection to the Plan of Rehabilitation submitted by the Wisconsin Office of the Insurance Commissioner as the court-appointed Rehabilitator for the Segregated Account. CAPCO objects to the Plan's treatment of any potential CAPCO claim against Ambac as a "general claim" rather than a "policy claim," as those terms are defined in the Plan. By classifying claims under a reinsurance contract as "general claims," the Plan effectively subordinates such claims to other "policy claims." Under the plain terms of the applicable Wisconsin statutes, a reinsurance agreement is entitled to treatment equal to that provided by the Plan for "policy claims."

The Plan and its related documents do not explain why reinsurance contracts are treated in this fashion, other than to suggest vaguely that they are "not entitled to priority." However, CAPCO has been advised by counsel for the Insurance Commissioner that the Plan's treatment of reinsurance contracts is based on the Commissioner's interpretation of Wis. Stat. § 645.68, which governs the "order of distribution" for creditors in a rehabilitation proceeding. *Affidavit of John Franke*, ¶ 8. CAPCO objects to this interpretation, and asks the Court to find that, as a matter of law, reinsurance contracts are entitled to treatment as "Loss Claims" under the terms of the statute and therefore entitled to treatment as "policy claims" under the terms of the Plan of Rehabilitation.

This conclusion follows unambiguously from the plain language of the statute, and it find further support in the statute’s legislative history. The Wisconsin courts have not had occasion to address the question of where a reinsurance contract claim falls in the order of priority established by Wis. Stat. § 645.68. Appellate courts in a number of other states have addressed similar statutes, and have concluded that reinsurance contracts should not be afforded the same priority status given to the claims of direct policy beneficiaries. However, these cases apply the case law, definitions and legislative history pertinent to their respective jurisdictions, and apply those considerations to statutory language that is different than the words of the Wisconsin statute. The language, case law, definitions and legislative history relevant to the interpretation of the Wisconsin statute are all unique and support a different result. For the reasons discussed below, the language of Wisconsin’s statute does not subordinate reinsurance contract claims to other “policy claims” in a Chapter 645 rehabilitation proceeding.

Background

The Court is fully familiar with the procedural background of this case, including the petition for rehabilitation filed by the Commissioner of Insurance on March 24, 2010 and the Plan of Rehabilitation subsequently filed on October 15, 2010. CAPCO’s connection to this Rehabilitation proceeding stems from a reinsurance contract between it and Ambac. A copy of this contract is attached as *Exhibit 1* to the Affidavit of Attorney John Franke.

The Customer Asset Protection Company, or CAPCO, is an insurance company formed by various securities firms for the purpose of providing additional protection to the firm clients for losses in the event that the firm should fail.¹ Such

¹ The background information in this paragraph and the two subsequent paragraphs relies on the Affidavit of Attorney John Franke, ¶¶ 2-7.

clients were already provided coverage for by the Securities Investor Protection Corporation; CAPCO was created to provide supplemental or “excess” protection for losses that exceeded the coverage provided by SIPC.

CAPCO was created in late 2003 and is licensed in the state of Vermont as an insurance company, but the only insurance it has provided is the coverage for firm clients described above. This coverage was accomplished by the issuance of various bonds to the member firms that provided for the payment of claims to clients who suffered losses exceeding amounts covered by SIPC. CAPCO’s contract with Ambac provides that Ambac would assume some of the risk that CAPCO would have to pay for claims made by brokerage firm clients under the terms of the bonds. Under this contract, Ambac and another company, Assured Guaranty Corporation, indemnified CAPCO for its losses if claims under the bonds exceeded certain amounts.

All of the outstanding bonds issued by CAPCO expired by February of 2009. No claims have been made against CAPCO at any time, and none can be made except possibly under bonds issued to Lehman Brothers Inc. and Lehman Brothers International (Europe). Because insolvency proceedings were commenced against this two entities prior to the expiration of the relevant bonds, a customers of those firms may have a claim as a beneficiary under the bonds. Several things must happen before a client can make a claim under the bonds, including the resolution of the complicated Lehman Brothers bankruptcy, and it is likely to be at least several years before CAPCO can determine whether it has any claim against Ambac under the terms of its reinsurance contract.

When the Segregated Account was created in connection with this rehabilitation proceeding, CAPCO’s contract with Ambac was placed in that account, along with several other reinsurance agreements. *See Petition for Rehabilitation, Schedule F.* The Petition for Rehabilitation, the Plan of Rehabilitation, and the many related documents filed by the Commissioner do not explain why CAPCO’s contract was placed in the

Segregated Account. It appears to have been based primarily on the Commissioner's view that such contracts were subordinate to claims made under other Ambac insurance contracts. See *Affidavit of John Franke*, ¶ 8.

The subordination of CAPCO's contract is not specifically discussed or explained in the Plan. This subordination is achieved by the definitions of "general claims" and "policy claims," which simply establish by definition that a claim under an insurance contract is a "general claim."

1.28 General Claims. All Claims which are not Administrative Claims or Policy Claims, and are not otherwise entitled to priority under the Act or an order of the Court, including, but not limited to, . . . (ii) any Claim submitted under a reinsurance agreement allocated to the Segregated Account, as identified in Exhibit F to the Plan of Operation.

1.48 Policy. Any financial guaranty insurance policy, surety bond or other similar guarantee allocated to the Segregated Account pursuant to the Plan of Operation.

1.49 Policy Claim. A Claim under a Policy or Policies.

Plan of Rehabilitation, at 5, 8. For the most part, the procedures for the handling of both types of claims are similar. However, the provisions for payment of such claims are very different. The Segregated Account will pay 25% of an approved policy claim in cash and provide the holder of the claim with a "Surplus Note" for the remaining 75%. Such notes bear an interest rate of 5.1% and mature on June 7, 2020. Approved general claims receive no cash, and are paid entirely with "Junior Surplus Notes," bearing the same interest rate and maturity date as Surplus Notes. Any and all of these payments are dependent on the Segregated Accounts ability to pay and are subject to the approval of the Commissioner. Most significantly, Junior Notes will not be paid until all Surplus Notes have been satisfied. Thus, CAPCO will not receive any

payment on its claims until all policy claims have been paid or the Commissioner is otherwise satisfied that such claims will be paid.

Legal Standards

A. Principles of Statutory Interpretation

The Wisconsin courts have discussed the principles that govern statutory interpretation many times, including the following summary in *Cesare Bosco v. Labor & Industry Review Commission*, set forth here with the numerous citations omitted:

When interpreting statutes, our goal is to give effect to the language in the statute. We begin by looking to the language of the statute because we “assume that the legislature’s intent is expressed in the statutory language.” Technical terms or legal terms of art appearing in the statute are given their accepted technical or legal definitions while nontechnical words and phrases are given their common, everyday meaning. Terms that are specifically defined in a statute are accorded the definition the legislature has provided. In addition, we read the language of a specific statutory section in the context of the entire statute. Thus, we interpret a statute in light of its textually manifest scope, context, and purpose.

If this process of analysis yields a plain, clear statutory meaning, then there is no ambiguity and the statute is applied according to this ascertainment of its meaning. If the statute is unambiguous, there is no need to resort to extrinsic sources such as legislative history; we simply apply the language of an unambiguous statute to the facts before us. A statute is not ambiguous merely because the parties disagree as to its meaning or because different courts have reached different conclusions. A statute is ambiguous if it is “readily susceptible to two or more meanings by reasonably well-informed individuals.”

2004 WI 77, ¶¶ 23-24; 272 Wis. 2d 586, 681 N.W.2d 157.

B. Standard of Review

The Commissioner’s interpretation of Wis. Stat. § 645.68 involves a question of law which is not binding upon a reviewing court. *Local 695 v. LIRC*, 154 Wis. 2d 75, 82

(1990). The courts generally apply one of three levels of deference to an agency's statutory interpretations: great weight, due weight, and *de novo* review. *Sauk County v. WERC*, 165 Wis. 2d 406, 413 (1991). However, under any standard of review, an agency's interpretation cannot be upheld if it is contrary to the clear meaning of the statute. *UFE Inc. v. LIRC*, 201 Wis. 2d 274, 287 (1996).

Under *de novo* review, there is no deference to the agency. This standard applies when the matter is one of first impression for the agency and where the agency lacks special expertise or experience in determining the questions presented. *Jicha v. DILHR*, 169 Wis. 2d 284, 291 (1992); *WSEU v. WERC*, 189 Wis. 2d 406, 411 (Ct. App. 1994). A second level of review, identified as due weight deference, is appropriate when the agency has some experience in an area, but has not developed the expertise which necessarily places it in a better position than the court to make judgments regarding statutory interpretation. *UFE Inc. v. LIRC*, at 287. Under this standard, the court will uphold a reasonable interpretation of the statute unless the court finds that there is a more reasonable interpretation.

Under the "great weight" standard, an agency's decision must be upheld if it is reasonable, even if the court believes a different conclusion might be more reasonable. Four requirements must be met in order for this level of deference to apply:

- (1) the agency was charged by the legislature with the duty of administering the statute;
- (2) that the interpretation of the agency is one of long-standing;
- (3) that the agency employed its expertise or specialized knowledge in forming the interpretation; and
- (4) that the agency's interpretation will provide uniformity and consistency in the application of the statute.

Harnischfeger Corp. v. LIRC, 196 Wis. 2d 650, 660 (1995).

Here, the record before the court does not identify the Commissioner's reasoning for the application of any particular interpretation of the statute, or demonstrate that the Commissioner has any particular expertise that places it in a

better position than the court to make a determination of the statutory intent, or establish that there has been a longstanding interpretation of these particular statutory provisions. Under such circumstances, the Commissioner's decision would be subject to *de novo* review or, at most, due weight deference. It is, however, CAPCO's position that the Commissioner's interpretation is contrary to the statute's plain meaning, and cannot be sustained even if given great weight deference.

Wis. Stat. § 645.68

The full text of Wis. Stat. § 645.68 is set forth in Appendix A. This statute sets a priority for the distribution of claims from the insurer's estate, a priority that applies to rehabilitation as well as liquidation. In order of priority, the first seven classification titles are as follows:

- (1) ADMINISTRATION COSTS.
- (3) LOSS CLAIMS
- (3c) FEDERAL GOVERNMENT CLAIMS AND INTEREST
- (3m) CERTAIN INJURY CLAIMS
- (3r) WAGES
- (4) UNEARNED PREMIUMS AND SMALL LOSS CLAIMS
- (5) RESIDUAL CLASSIFICATION.²

At issue here is whether a reinsurance contract claim is a loss claim under (3) or part of the residual classification under (5). CAPCO contends that its potential claims belong under subsection (3); the Commissioner apparently believes CAPCO's claims fall under the "residual classification" of subsection (5). The pertinent portions of subsections (3) and (5) are as follows:

² There is no subsection (2) at this time, although there was in the original list of classifications. This will be discussed in connection with the legislative history below. The classifications after subsection (5) are (6) JUDGMENTS; (7) INTEREST ON CLAIMS ALREADY PAID; (8) MISCELLANEOUS SUBORDINATED CLAIMS; (9) BONDS; (10) CONTRIBUTION NOTES; (11) PROPRIETARY CLAIMS. *See* Appendix A.

(3) LOSS CLAIMS. All claims under policies for losses incurred, including 3rd-party claims and federal, state, and local government claims, except the first \$200 of losses otherwise payable to any claimant under this subsection other than the federal government. . . .

(5) RESIDUAL CLASSIFICATION. All other claims, including claims of any state or local government, not falling within other classes under this section and claims described in s. 645.69. Claims, including those of any state or local governmental body, for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under sub. (8).

ARGUMENT

I. The Plain Language of the Statute Requires that a Reinsurance Contract Claims be Treated as a Loss Claim Under Subsection (3).

Wis. Stat. § 645.68 does not specifically refer to “reinsurance contracts.” However a the plain language of the statute place claims under such contracts clearly within the scope of the “Loss Claims” in subsection (3) and under no other subsection. The description of “Loss Claims” begins by including “All claims under policies for losses incurred . . .” CAPCO’s claims against Ambac will be for losses it incurs by having to pay client claims under the terms of its bonds. Thus, the only question is whether a reinsurance contract is a “policy” as that term is used in this very simple phrase.

Wis. Stat. § 600.03 provides a long list of definitions applicable to Chapter 645, and includes this definition of “policy”:

(35) “Policy” means any document other than a group certificate used to prescribe in writing the terms of an insurance contract, including endorsements and riders and service contracts issued by motor clubs.

Section 600.03 does not define “insurance contract,” but it seems beyond dispute that a reinsurance contract is a type of insurance contract and that the CAPCO contract with Ambac is a “document used to prescribe in writing the terms of an insurance contract.”³

Wisconsin case law has repeatedly endorsed a broad definition of insurance, and there is nothing to suggest that insurance does not include reinsurance. In *Shakman v United States Credit System*, 66 N.W. 528 (1896), the court concluded that a contract whereby the defendant company guaranteed a merchant against losses resulting from the insolvency of its customers was an insurance contract:

An insurance contract is a contract whereby one party agrees to wholly or partially indemnify another for loss of damage which he may suffer from a specified peril. The peril of loss by the insolvency of customers is just as definite and real a peril to a merchant or manufacturer as the peril of loss by accident, fire, lightning, or tornado, and is, in fact, much more frequent.

66 N.W. 528, at 531. This definition was cited favorably in *Sims v. Manson*, 25 Wis.2d 110,114 (1964), along with this definition from the federal court of appeals:

. . . insurance involves essentially a contractual security against anticipated loss. The risk of loss on the part of the insured is occasioned by some future or contingent event, and is shifted to or assumed by the insurer. There is also a distribution of the risk of loss by the payment of a premium or other assessment into a general fund.

[citing *Metropolitan Policy Retiring Assoc., Inc. v. Tobriner*, 113 U.S. App. D.C. 168, 170, 306 F.2d 775, 777 (1962)].

The CAPCO contract with Ambac indisputably satisfies this concept of insurance and the definition of “policy.” It therefore fits the plain language of “Loss

³ Section 600.03(25) establishes that “insurance” includes certain particular things, but does not define the term. Section 600.02(2) confirms that “Statements that a term ‘includes’ or ‘excludes’ something else are not definitions.”

Claims.” There is no reason to look elsewhere in the statute for an appropriate classification and no reason to relegate such claims to the “residual classification.”

***II. If Necessary, the Legislative History
Demonstrates a Legislative Intent that Reinsurance
Claims be Included as Loss Claims.***

For reasons discussed above, there is no ambiguity in the statutory scheme that requires resort to extrinsic evidence of legislative intent. Just as the statute does not reference claims under reinsurance contract, the legislative history does not mention such claims. However, should the court find that the plain language and definitions discussed above are not sufficiently clear, the legislative history demonstrates the same intent as is conveyed by the words of the statute, that is, that reinsurance policy claims are to be treated as “Loss Claims.”

A. The Creation of Chapter 645

Chapter 645 was created as a part of Act 89 of 1967. This Act included extensive and detailed comments, and the pertinent portions of the Act are included as Appendix B.⁴ Just as the statute does not reference claims under reinsurance contract, these comments do not mention reinsurance contracts. However, the comments to the Act clearly support three relevant conclusions with respect to the legislative intent regarding reinsurance claims:

- reinsurance claims do not belong in subsection (5);
- such claims logically belong above the claims placed in subsection (4);
- nothing suggests a legislative intent to remove or exclude such claims from subsection (3).

⁴ Appendix B includes the list of all sections of the new Chapter 645, the Preliminary Comment for the entire chapter, and the particular statutory language and comments for § 645.68.

While the original classifications differ somewhat from the current list, for purposes of the priority of claims issue before the Court, the classifications and order of priority were quite similar. The first five classification titles in the initial version of Chapter 645 were as follows:

- (1) ADMINISTRATION COSTS.
- (2) WAGES
- (3) LOSS CLAIMS
- (4) UNEARNED PREMIUMS AND SMALL LOSS CLAIMS
- (5) RESIDUAL CLASSIFICATION.

As with the discussion of the current statute above, the question at hand is whether a reinsurance contract claim falls in the Loss Claim category or the Residual Classification.

In determining the answer to this question, the comments with respect to subsections (3), (4) and (5) are all helpful. The “Introductory comment” to § 645.68 includes a brief description of these three categories, with more detailed comments following the statutory language for each of the categories. The “Introductory comment” includes the following:

(3) *Loss claims.* This is limited to large claims, the cases where the most hardship will result if full payment is not made reasonably promptly.

(4) *Unearned premium reserve and small loss claims.* If this priority can be reached and these claims paid in full, the enterprise will have carried out the social function of insurance in a reasonably adequate way.

(5) *Residual classification.* This includes ordinary commercial debts and debts owing to governments, such as taxes. It is likely to be small in amount relative to the total of all claims.

Appendix B, at 7.

B. Subsection (5): RESIDUAL CLASSIFICATION

The introductory comment cited above indicates that this category includes “ordinary commercial debts” and debts to government, such as taxes. The more detailed comment following the statutory language of subsection (5) begins as follows:

Comment on sub. (5): This is the residual classification, and includes a great variety of claims; though in aggregate amount, it will usually be unimportant. This priority and all below it are of relatively lesser social importance. They are just debts, having no significant relationship to the important role insurance plays in our society.

Appendix B, at 10.⁵ The comments cited above demonstrate that this category was not intended to include reinsurance claims. Such claims are not likely to be small. They are not “just debts,” nor are they “unimportant.” Rather, they are directly related to the role that insurance plays in our society, namely, allowing one person or entity to shift risk to an entity that is in a better position to handle that risk. Reinsurance claims obviously have no business being placed in this category.

C. Subsection (4): UNEARNED PREMIUMS AND SMALL LOSS CLAIMS

The full comment following the statutory language of subsection (4) is as follows:

Comment on sub. (4): Unearned premium claimants are placed in line after loss claimants, to help ensure the continuity of insurance protection, and the performance of insurer functions. The holders of assessable policies are not granted any such priority since traditionally their payments are regarded as partially in the nature of capital contributions. With unearned premiums is included the “deductible” portion of loss claims from sub. (3).

Appendix B at 10. This comment makes clear an intent that the liquidated company is expected to perform its essential insurance function, that is, covering the risks it had agreed to cover, *before* reimbursing claimants whose payments to the company “are regarded as partially in the nature of capital contributions.” This clearly evidences an intent that all insurance claims, including reinsurance claims, be satisfied before subsection (4) claims are paid. If reinsurance claims must wait until after claims under subsection (4), the introductory comment to subsection (4) makes no sense. Until

⁵ The balance of this very lengthy comment is concerned with the handling of government debts and whether the subordinate treatment of government debts is consistent with federal law.

such claims are made, the enterprise has not carried out the social function of insurance, as that term has been broadly defined, in a reasonably adequate way.

D. Subsection (3): LOSS CLAIMS

The comment following the statutory language of subsection (3) begins as follows:

Comment on sub. (3): This class contains the claims central to the social role of insurance. The typical policy is not an ordinary mercantile contract, but one of great public importance. In the usual case, if a policyholder loses a premium, he is not seriously harmed, but if a loss goes unpaid, or even unpaid in substantial measure, great harm is likely to be done. Large claims deserve a higher priority than unearned premiums, and this system has so provided.

Small loss claims are subordinated to large claims and put on a par with unearned premiums, in order to increase the likelihood of full payment of disaster-type claims. This is the point of the \$200 deduction. In the usual case, a small loss may be absorbed by the claimant without serious hardship, and therefore does not deserve or need priority above unearned premiums. The larger the claim the more likely it is that substantial payment to the claimant is urgently needed.

Appendix B at 9. As the Ambac rehabilitation case demonstrates, insurance takes many different forms and covers many different types of risk. Nothing about the other “policies” placed in the Segregated Account makes them any more “central to the social role of insurance” than is CAPCO’s contract with Ambac. In fact, the Ambac policies that insured Credit Default Swap agreements and Residential Mortgage Backed Securities are far less a part of the traditional social role of insurance than is CAPCO’s effort protect the customers of participating securities firms. Nothing suggests that the investment firms and financial institutions that are the Ambac “policyholders” the Court has heard from in this case are any more vulnerable than is CAPCO or any more in need of protection during a rehabilitation proceeding.

Moreover, the reference to the subordination of “small claims” does not apply to reinsurance claims. By their nature, those are likely to be “large.” As this case illustrates, the handful of reinsurance contracts placed in the Segregated Account represented \$20 billion of the total of \$67 billion in net per outstanding estimated to apply to the policies assigned to the Segregated Account. *Affidavit of Roger Peterson*, filed

May 20, 2010, at 7, ¶ 10. Such large claims do not fit within the intended scope of the Residual Classification in subsection (5).

E. Cases from Other Jurisdictions.

CAPCO expects that the Commissioner will rely on appellate decisions from a number of other states that have addressed similar statutes, and acknowledges that such decisions have concluded that reinsurance contracts should not be afforded the same priority status given to the claims of other policy beneficiaries. *See*, for example, *Covington v. Ohio General Ins. Co.*, 99 Ohio St. 3d 117, 789 N.W.2d 213 (2003); *In re Liquidations of Reserve Ins. Co., et al.*, 122 Ill. 2d 555, 524 N.E.2d 538, 120 Ill. Dec. 508 (1988); *Cherokee Ins. Co. v. Pine Top Insurance Co.*, 704 S.W.2d 1 (1986).

However, these cases apply the case law, definitions and legislative history pertinent to their respective jurisdictions, and apply those considerations to statutory language *that is different than the words of the Wisconsin statute*. None of these cases deals with the Wisconsin statutory language and none of the cases reference any statutory definition of “policy,” much less the same definition that applies to the Wisconsin statute. The Ohio case, as an example, relies on a number of other statutory provisions that demonstrate an intent by the Ohio General Assembly to differentiate between direct consumer insurance and reinsurance. None of these Ohio statutes apply to the interpretation of Wis. Stat. § 645.68. The Illinois case gives considerable weight to a statutory definition of “reinsurance,” a definition that has no application here. The language, case law, definitions and legislative history relevant to the interpretation of the Wisconsin statute are all unique and support a different result than was reached in these foreign jurisdictions.

Conclusion

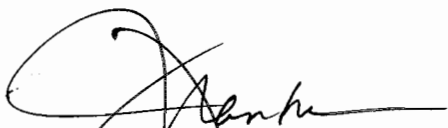
For all of the reasons discussed above, the language of Wis. Stat. § 645.68 does not subordinate reinsurance contract claims to other “policy claims” in a Chapter 645

rehabilitation proceeding. CAPCO respectfully requests that the Court uphold its objection to the Plan of Rehabilitation in this regard.

Dated this 8th day of November, 2010.

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645.68 Order of distribution. The order of distribution of claims from the insurer's estate shall be as stated in this section. The first \$50 of the amount allowed on each claim in the classes under subs. (3) to (6), except for claims of the federal government under subs. (3) and (3c), shall be deducted from the claim and included in the class under sub. (8). Claims may not be cumulated by assignment to avoid application of the \$50 deductible provision. Subject to the \$50 deductible provision, every claim in each class shall be paid in full or adequate funds retained for the payment before the members of the next class receive any payment. No subclasses shall be established within any class. That portion of any loss for which indemnification is provided by other benefits or advantages recovered or recoverable by the claimant shall not be included in the classes under subs. (3) and (3m), other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment made by an employer to an employee shall be treated as a gratuity. The claims described in s. 645.69 are among the claims not subject to subs. (3) and (3m).

(1) ADMINISTRATION COSTS. The costs and expenses of administration, including but not limited to the following: the actual and necessary costs of preserving or recovering the assets of the insurer; compensation for all services rendered in the liquidation; any necessary filing fees; the fees and mileage payable to witnesses; and reasonable attorney fees.

(3) LOSS CLAIMS. All claims under policies for losses incurred, including 3rd-party claims and federal, state, and local government claims, except the first \$200 of losses otherwise payable to any claimant under this subsection other than the federal government. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values, shall be treated as loss claims. Claims may not be cumulated by assignment to avoid application of the \$200 deductible provision.

(3c) FEDERAL GOVERNMENT CLAIMS AND INTEREST. Claims of the federal government not included under sub. (3), and interest at the legal rate compounded annually on all claims in the class under this subsection, and on all claims of the federal government in the class under sub. (3), from the date of the petition for liquidation or the date on which the claim becomes due, whichever is later, until the date on which the dividend is declared.

(3m) CERTAIN INJURY CLAIMS. Claims against the insurer that are not under policies and that are for liability for bodily injury or for injury to or destruction of tangible property.

(3r) WAGES. (a) Debts due to employees for services performed, not to exceed \$1,000 to each employee which have been earned within one year before the filing of the petition for liquidation. Officers shall not be entitled to the benefit of this priority.

(b) Such priority shall be in lieu of any other similar priority authorized by law as to wages or compensation of employees.

(c) Notwithstanding pars. (a) and (b) and subs. (3), (3c) and (3m), if there are no claims of the federal government, the claims in the class under this subsection shall have priority over all claims in the classes under subs. (3) to (11).

(4) UNEARNED PREMIUMS AND SMALL LOSS CLAIMS. Claims under nonassessable policies for unearned premiums or other premium refunds and the first \$200 of loss excepted by the deductible provision in sub. (3).

(5) RESIDUAL CLASSIFICATION. All other claims, including claims of any state or local government, not falling within other classes under this section and claims described in s. 645.69. Claims, including those of any state or local governmental body, for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under sub. (8).

(6) JUDGMENTS. Claims based solely on judgments. If a claimant files a claim and bases it both on the judgment and on the underlying facts, the claim shall be considered by the liquidator who shall give the judgment such weight as he or she deems appropriate. The claim as allowed shall receive the priority it would receive in the absence of the judgment. If the judgment is larger than the allowance on the underlying claim, the remaining portion of the judgment shall be treated as if it were a claim based solely on a judgment.

(7) INTEREST ON CLAIMS ALREADY PAID. Interest at the legal rate compounded annually on all claims in the classes under subs. (1) to (6), except for claims of the federal government in the classes under subs. (3) and (3c), from the date of the petition for liquidation or the date on which the claim becomes due, whichever is later, until the date on which the dividend is declared. The liquidator, with the approval of the court, may make reasonable classifications of claims for purposes of computing interest, may make approximate computations and may ignore certain classifications and time periods that are trifling.

(8) MISCELLANEOUS SUBORDINATED CLAIMS. The remaining claims or portions of claims not already paid, with interest as in sub. (7):

(a) Except for claims of the federal government under subs. (3) and (3c), the first \$50 of each claim in the classes under subs. (3) to (6) subordinated under this section.

(b) Claims under s. 645.63 (2).

(c) Claims subordinated by s. 645.90.

(d) Claims filed late.

(e) Portions of claims subordinated under sub. (5).

(f) Claims or portions of claims payment of which is provided by other benefits or advantages recovered or recoverable by the claimant.

(g) Any indemnification recovered as a voidable preference under s. 645.54 (1) (c).

(9) BONDS. The claims of the holders of bonds, under s. 611.33 (2) (a), 613.33 (1) or 614.33, including interest thereon.

(10) CONTRIBUTION NOTES. The claims of the holders of contribution notes under ss. 611.33 (2) (b), 613.33 (2) and 614.33, including interest thereon.

(11) PROPRIETARY CLAIMS. The claims of shareholders or other owners, including policyholders of a mutual insurance corporation within the limits of s. 645.72 (2).

History: 1971 c. 260; 1979 c. 93; 1979 c. 102 s. 236 (5); 1979 c. 110; 1989 a. 23, 359; 1993 a. 490; 1999 a. 30; 2005 a. 253.

CHAPTER 89, LAWS OF 1967

AN ACT to repeal 20.460 (1) (j), 200.08 (1) to (5), (7) and (8), 200.09, 200.26 (9), 201.13 (1) and (2), 201.27 (2), 201.51 and chapter 616; to renumber 201.27 (1); to renumber and amend 200.08 (6) and 201.13 (3); to amend 102.65 (15), 200.03 (18), 201.16 (2), 206.19 and 286.12; and to create chapter 645 of the statutes, relating to delinquency proceedings in insurance.

* * *

CHAPTER 645.

INSURERS REHABILITATION AND LIQUIDATION.

SUBCHAPTER I.

GENERAL PROVISIONS.

- 645.01 Title, construction and purpose.
- 645.02 Persons covered.
- 645.03 Definitions.
- 645.04 Jurisdiction and venue.
- 645.05 Injunctions and orders.
- 645.06 Costs and expenses of litigation.
- 645.07 Co-operation of officers and employes.
- 645.08 Bonds.
- 645.09 Commissioner's report.
- 645.10 Continuation of delinquency proceedings.

SUBCHAPTER II

SUMMARY PROCEEDINGS.

- 645.21 Commissioner's summary orders.
- 645.22 Court's seizure order.
- 645.23 Commissioner's seizure order.
- 645.24 Conduct of hearings in summary proceedings.

APPENDIX B

SUBCHAPTER III.
FORMAL PROCEEDINGS.

- 645.31 Grounds for rehabilitation.
- 645.32 Rehabilitation orders.
- 645.33 Powers and duties of the rehabilitator.
- 645.34 Actions by and against the rehabilitator.
- 645.35 Termination of rehabilitation.
- 645.41 Grounds for liquidation.
- 645.42 Liquidation orders.
- 645.43 Continuance of coverage.
- 645.44 Dissolution of insurer.
- 645.45 Federal receivership.
- 645.46 Powers of liquidator.
- 645.47 Notice to creditors and others.
- 645.48 Duties of agents.

- 645.49 Actions by and against liquidator.
- 645.51 Collection and list of assets.
- 645.52 Fraudulent transfers prior to petition.
- 645.53 Fraudulent transfers after petition.
- 645.54 Voidable preferences and liens.
- 645.55 Claims of holders of void or voidable rights.
- 645.56 Set-offs and counterclaims.
- 645.57 Assessments.
- 645.58 Reinsurer's liability.
- 645.61 Filings of claims.
- 645.62 Proof of claim.
- 645.63 Special claims.
- 645.64 Special provisions for third party claims.
- 645.65 Disputed claims.
- 645.66 Claims of surety.
- 645.67 Secured creditors' claims.
- 645.68 Order of distribution.
- 645.71 Liquidator's recommendations to the court.
- 645.72 Distribution of assets.
- 645.73 Unclaimed and withheld funds.
- 645.74 Termination of proceedings.
- 645.75 Reopening liquidation.
- 645.76 Disposition of records during and after termination of liquidation.
- 645.77 External audit of receiver's books.

SUBCHAPTER IV.
INTERSTATE RELATIONS

- 645.81 Conservation of property of foreign or alien insurers found in this state.
- 645.82 Liquidation of property of foreign or alien insurers found in this state.
- 645.83 Foreign domiciliary receivers in other states.
- 645.84 Ancillary formal proceedings.
- 645.85 Ancillary summary proceedings.
- 645.86 Claims of nonresidents against insurers domiciled in this state.
- 645.87 Claims of residents against insurers domiciled in reciprocal states.
- 645.88 Attachment, garnishment and levy of execution.
- 645.89 Interstate priorities.
- 645.90 Subordination of claims for non-co-operation.

PRELIMINARY COMMENT: This chapter is the first product of the comprehensive study and revision of the insurance laws authorized by s. 13.84. It re-examines and comprehensively redesigns all aspects of delinquency proceedings in insurance. Its purpose can best be understood in relation to the problems it attempts to solve.

Basic Problems

Several major groups of problems can be isolated for consideration in a study of delinquency proceedings in insurance. As they appear in logical sequence they are as follows:

- (1) The causes of insolvency,
- (2) The detection of incipient difficulty in the insurance company operation,
- (3) The devising of ways to induce the insurance commissioner to take early action to correct remediable defects in insurer operation, before the sickness has become serious,

(4) The provision of effective procedures for rehabilitation of companies seriously sick but still salvageable,

(5) For companies that cannot be saved, the development of efficient, inexpensive, and expeditious procedures for liquidation that will distribute the unavoidable burden fairly, and

(6) The complications superimposed on the above problems by the existence of a federal system as the setting for delinquency proceedings.

This chapter deals with all of these groups of problems, though with some much more than with others. The first 2 are treated least fully, because they are more closely connected with substantive regulation than with delinquency proceedings. The others are dealt with in succession.

Insurance commissioners do not now deal with difficulty in insurance company operation, in many instances at least, until long after it is common knowledge in the industry and even in regulatory circles that the company is in serious trouble. Reluctance to take effective action despite adequate knowledge is a fundamental problem of insurance regulation, and this chapter has approached the solution of that problem by providing new summary procedures.

Summary Procedures

In order to encourage early action by the commissioner of a more discriminating sort than is possible using traditional methods, very flexible summary procedures were devised. Since the commissioner has previously had available to him only rather gross methods that usually involved the destruction of the company through liquidation or through an ineffective effort to save it by formal and public rehabilitation procedures, he has often been hesitant to take action until all hope was lost. Moreover, when he has merely suspected difficulty he has been unwilling to proceed because he was not sure of his ground for action and because the publicity attendant upon any proceeding was destructive of the company.

It is true that under former s. 200.09, the commissioner has had summary power to seize an insurance company in an emergency, but he has never used it. That restraint seems wise since the statute was devised to deal with bank insolvencies and is poorly designed for insurance companies. Hence it is necessary to equip the commissioner with a variety of discriminating weapons that will enable him to deal effectively and promptly with incipient difficulty, if he will use them. Unlike traditional regulatory tools, the new procedures are designed to eliminate unnecessary damage to the insurer and needless intervention in the industry.

There should be no reason why the commissioner would not use the new procedures. They are not novel devices; they have counterparts in the Wisconsin banking law and in similar procedures in the California insurance statutes. Nor are they dangerous. They are hedged about with procedural safeguards against arbitrariness by the commissioner, including quick and easy access to judicial review. Moreover, because they can be used with minimum publicity and less massive intervention, they can be used with less risk of destruction and interference with the company and are thus less dangerous than more formal methods.

The chapter creates 2 kinds of summary procedures, one a simple order, either mandatory or inhibitory, and the other a seizure order. Normally, the former type of order would be obtained after a hearing; in emergency situations the commissioner may issue such an order without hearing, but subject to immediate and speedy court control at the instance of the company. The seizure order would normally be issued by a court, and only in an emergency by the commissioner.

These devices will enable the commissioner to deal effectively with single practices that endanger the company solvency or the public interest. Where venal manipulation of assets is feared, he will be able to seize assets and books quickly enough to protect them and to learn what is happening. The prospect of immediate court supervision and the possibility of devastating criticism of his action in the insurance world where he values his reputation highly will suffice to keep the commissioner from abusing this carefully limited power. In addition, a commissioner will not be unaware of possible tort liability if he should act improperly. Indeed, the greater difficulty is to give the commissioner sufficiently discriminating weapons to induce him to act as soon as he should; nearly always he is inclined to do nothing until it is too late.

Formal Procedures

The summary proceedings just described will not always be appropriate. When difficulties have reached a certain point, more formal action is necessary. Statutes generally distinguish between rehabilitation and liquidation, and this distinction is retained. However, rehabilitation has been conceived heretofore in the same legalistic way as liquidation—the problem is seen erroneously as one of undertaking formalized legal action to save the company—perhaps through merger, consolidation, mutualization, conversion to the stock form, or other reorganization. Occasionally these formal devices may be useful, but the emphasis has been altogether misplaced.

What is needed for rehabilitation of an insurance company is new management with the capacity to see what is wrong and the power to correct it. The chapter, therefore, tries to devise a rehabilitation procedure with a focus on management expertise. The key to success is twofold. Early action is one-half and obtaining a satisfactory rehabilitator the other half. The rehabilitator cannot be the insurance commissioner, except in a formal sense, for the commissioner has too many other things to do and may or may not know how to manage an insurance company, however able he may be as a regulator. He should not be a practicing lawyer, unless he is also management oriented and trained. He should be a manager of talent and experience in the insurance business. It is important to draw from the industry an experienced executive of recognized ability who will regard it both as his public duty and his private opportunity to save the company.

To obtain the "right" person requires help from the industry. If they will, insurance executives can help find the man and can help convince him and his present employer that on the grounds of public service and private career opportunity he must take the job. He should be compensated liberally so that he does not lose financially. He should then be given wide discretion in management, subject only to general court supervision, so that he can take such action as is necessary to revitalize the company. Conceptually he should be treated as new management with especially broad powers, including the power to propose to the court the formal legal reorganizational devices that have heretofore been the focus of rehabilitation but that should normally be subordinated in the future to the larger management task. This change is more one of "tone"—of attitude—than of change in the formally stated rules. But tone or attitude can be a decisive factor in achieving success in a complex undertaking.

Grounds for Formal Proceedings

Traditionally the grounds upon which action might be instituted against an insurer were the same for rehabilitation as for liquidation, the choice between remedies depending on an estimate of probable success if the former were attempted. The chapter retains this notion in part but tries to tailor it to reality. Rehabilitation is not appropriate at a point where a company has been allowed to approach insolvency, unless substantial additional resources are poured into the enterprise *immediately* by contributors of capital funds. A serious error in recent insurance regulation has been the futile hope that insolvent enterprises might yet survive,

held long after it was too late. Consequently the grounds are now separate: those that suggest insolvency are grounds for liquidation while those that indicate only difficulty of a different order are now grounds for rehabilitation. Flexibility is preserved (1) by making either procedure *possible* on any ground, though the chapter points the procedure in one direction or the other, depending on the situation, and (2) by permitting conversion from one type of proceeding to the other.

One indication of approach is the elimination of failure to remedy an impairment of capital after a commissioner's order as a ground for liquidation. Insolvency now includes every case of impairment of capital; whenever an order to restore impaired capital is necessary, it is too late and the company should be put into liquidation. Generosity on this matter would be misplaced. The only exception to a rule that such a company should be liquidated immediately is if money is poured into the enterprise so quickly that it is again clearly solvent before the commissioner irreversibly commits the company to the liquidation process. He should not wait to begin to do what is necessary to protect the public while efforts are made to find money.

Liquidations

Liquidation is an unfortunate end to an enterprise, to be handled as efficiently and expeditiously and economically as possible and with as equitable as possible an allocation of the inevitable loss.

The influence of the Federal Bankruptcy Act is quite apparent in the sections dealing with liquidation. That act provides a time tested, though not ideal, source for liquidation procedures. But the Act has not been blindly followed, when the special problems of insurance liquidation and regulation or other considerations urge a departure from the model.

The chapter tries to provide for an orderly and complete procedure; for a technique for the handling of claims, especially third party claims, in which everyone makes some concessions to the common necessity and no one suffers too much; for a system of priorities in claims that will enable some classes of claims to be paid earlier than they are now and that will ensure that the insurance company comes as close as possible to performing its social function even in its death throes; for powerful and discriminating devices to recover assets improperly dissipated while the patient was in a coma.

645.68 Introductory comment: When an insurer must be liquidated, the outcome is often tragic. While many of the losers will merely be inconvenienced, others may suffer losses or delays in receiving payment that will subject them at least to hardship and may even deprive them of the necessities of life. It becomes apparent that claims that are socially more important need to be paid ahead of those that are less important. Recognition of such social equities is commonplace in the law relating to insolvency and bankruptcy.

In an effort to minimize the harm done by liquidation, and especially to lessen it for those persons least able to bear it, much thought and consultation went into the structuring of the priority system. The outcome is the classification that follows. Because of the novelty of certain parts of the system, a full explanation for the placement of each category is provided. The basic nature of the system is explained briefly in the following outline, however, to provide an overview.

The order of distribution is:

(1) *Cost of administration.* Without this, the liquidation could not proceed and no distribution could be made. These costs generally come first in all priority systems.

(2) *Wages, in limited amounts.* This is traditionally a high priority and seems obviously meritorious in a society where the majority of people are dependent for a livelihood upon regular receipt of wages.

(3) *Loss claims.* This is limited to large claims, the cases where the most hardship will result if full payment is not made reasonably promptly.

(4) *Unearned premium reserve and small loss claims.* If this priority can be reached and these claims paid in full, the enterprise will have carried out the social function of insurance in a reasonably adequate way.

(5) *Residual classification.* This includes ordinary commercial debts and debts owing to governments, such as taxes. It is likely to be small in amount relative to the total of all claims.

(6) *Claims based solely on judgments.* Those judgments that cannot otherwise be avoided for constitutional reasons are postponed to this class to protect other claimants against inflated claims that are not properly defended because of the deterioration of the company in its last days. If the claim is meritorious, the judgment creditor can elevate his claim to the priority it would otherwise have by proving it in the liquidation on its merits and not on the basis of the judgment. The judgment may, of course, be a very persuasive fact.

(7) *Interest on claims paid in the classes of higher priority.*

(8) *Miscellaneous subordinated claims.* These are left to the last because of their minimal social importance or because of the necessities of administration. The category includes late claims and claims where the claimant is compensated in other ways, among others.

This section is designed to establish a complete system of priorities among unsecured creditors, based on the relative social and economic importance of the claims likely to be asserted against an insurer. The system is more intricate than any list of priorities provided elsewhere. It would be possible to simplify the system by having fewer categories. This is what the traditional priority system does, for it generally gives priority only to a few kinds of claims—indeed, the traditional pattern is no system at all. Its crude simplicity does crude injustice and fails to carry out sound public policy by minimizing the damage done to the insured community when an insurer fails. The insurance enterprise should be made to do its proper job in the social organism, so far as that is possible with the limited assets that remain in a liquidation.

645.68 ORDER OF DISTRIBUTION. The order of distribution of claims from the insurer's estate shall be as stated in this section. The first \$50 of the amount allowed on each claim in the classes under subs. (2) to (6) shall be deducted from the claim and included in the class under sub. (8). Claims may not be cumulated by assignment to avoid application of the \$50 deductible provision. Subject to the \$50 deductible provision, every claim in each class shall be paid in full or adequate funds retained for the payment before the members of the next class receive any payment. No subclasses shall be established within any class.

(1) **ADMINISTRATION COSTS.** The costs and expenses of administration, including but not limited to the following: the actual and necessary costs of preserving or recovering the assets of the insurer; compensation for all services rendered in the liquidation; any necessary filing fees; the fees and mileage payable to witnesses; and reasonable attorney's fees.

Comment on sub. (1): This is freely adapted from the first priority provision in Federal Bankruptcy Act s. 64a. See also s. 645.06, on defense costs, for a special provision for payment of certain litigation expenses.

(2) **WAGES.** (a) Debts due to employes for services performed, not to exceed \$1,000 to each employe which have been earned within one year before the filing of the petition for liquidation. Officers shall not be entitled to the benefit of this priority.

Comment on sub. (2) (a): The usual wage priority is \$600 (see e.g. Federal Bankruptcy Act s. 64a). It seems unrealistically low. The \$1,000 provided here may still be low but is more realistic and equitable. The period covered is extended from the 3 months of the traditional statute to one year. Obviously the \$1,000 limit would be reached much earlier than a year, if a full salary for even the lowliest employe were in question. The one year limit will be relevant only in unusual cases. Priority is denied to officers (which term includes directors), on the grounds that they are in a position to protect their own interests, and that those directly involved in what is likely to have been mismanagement leading to liquidation should not be accorded special privileges in a financial debacle of their own making.

(b) Such priority shall be in lieu of any other similar priority authorized by law as to wages or compensation of employes.

Comment on sub. (2) (b): This is necessary to supersede such provisions as ss. 180.40 (6) and 268.17. For analogous legislation to this paragraph, see Arizona s. 20-637B; Hawaii s. 181-678 (b); Kentucky s. 304.978 (2); North Carolina s. 558-155.27 (b); Washington s. 48.31.280 (2).

(3) **LOSS CLAIMS.** All claims under policies for losses incurred including third party claims, and all claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property which are not under policies, except the first \$200 of losses otherwise payable to any claimant under this subsection. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds or investment values, shall be treated as loss claims. Claims may not be cumulated by assignment to avoid application of the \$200 deductible provision. That portion of any loss for which indemnification is provided by other benefits or advantages recovered or recoverable by the claimant shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment made by an employer to his employe shall be treated as a gratuity. *Comment on sub. (3):* This class contains the claims central to the social role of insurance. The typical policy is not an ordinary mercantile contract, but one of great public importance. In the usual case, if a policyholder loses a premium, he is not seriously harmed, but if a loss goes unpaid, or even unpaid in substantial measure, great harm is likely to be done. Large claims deserve a higher priority than unearned premiums, and this system has so provided.

Small loss claims are subordinated to large claims and put on a par with unearned premiums, in order to increase the likelihood of full payment of disaster-type claims. This is the point of the \$200 deduction. In the usual case, a small loss may be absorbed by the claimant without serious hardship, and therefore does not deserve or need priority above unearned premiums. The larger the claim the more likely it is that substantial payment to the claimant is urgently needed.

The investment element of life insurance and annuity contracts is here treated as a loss claim. Life insurance and annuity policies present a complex array of investment and insurance mixtures which would often be difficult to classify as either loss claims or claims for investment values. Furthermore, the economic function and social importance of these investment values closely parallel those of loss claims in general. To avoid administrative difficulty and to give proper recognition to the social values in question, all claims under life and annuity policies are placed in this priority and are given loss claim status.

The 2nd group of claims against the insurer, for "liability for bodily injury or for injury to or destruction of tangible property which are not under policies," avoids the anomaly of giving insured liability claimants a high priority while subordinating other identically situated claimants who are unprotected by the benefits of liability insurance. This might happen, for example, if the insurer were self-insured (or *not* insured) for its own public liability. The words "bodily injury" rather than "personal injury" are used in the definition of this group to eliminate from this priority uninsured claims for libel, slander, invasion of privacy, false imprisonment, etc., which are less likely to generate actual out-of-pocket economic losses. The words "injury to or destruction of tangible property" are used in order to eliminate from this priority uninsured claims for intangible property losses (e.g. invasion of copyright) which are also less likely to generate out-of-pocket economic losses. These excluded claims would fall into the residual classification in sub. (5).

Under prior practice, it was possible for a claimant to be compensated legitimately more than once for certain kinds of losses. Because of their lesser social importance, this section subordinates any portion of a claim the payment of which would result in double compensation.

(4) **UNEARNED PREMIUMS AND SMALL LOSS CLAIMS.** Claims under non-assessable policies for unearned premiums or other premium refunds and the first \$200 of loss excepted by the deductible provision in sub. (3). *Comment on sub. (4):* Unearned premium claimants are placed in line after loss claimants, to help ensure the continuity of insurance protection, and the performance of insurer functions. The holders of assessable policies are not granted any such priority since traditionally their payments are regarded as partially in the nature of capital contributions. With unearned premiums is included the "deductible" portion of loss claims from sub. (3).

(5) **RESIDUAL CLASSIFICATION.** All other claims including claims of the federal or any state or local government, not falling within other classes under this section. Claims, including those of any governmental body, for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under sub. (8).

Comment on sub. (5): This is the residual classification, and includes a great variety of claims, though in aggregate amount, it will usually be unimportant. This priority and all below it are of relatively lesser social importance. They are just debts, having no significant relationship to the important role insurance plays in our society.

The last 2 sentences are similar to Federal Bankruptcy Act s. 57j. It is sound policy to disallow or subordinate such claims. The Bankruptcy Act provision does for governmental claims what general contract law does for similar claims of private parties. See MacLachlan, *Bankruptcy* 140 (1956). Here, as a precaution, the rule is made clearly applicable to private penalties and forfeitures as well. Whether the claims of the federal government can be placed this far down on the priority list depends on the following analysis justifying subordination of other governmental claims to this class.

In this residual classification fall most of the claims by government that are traditionally given a high priority. There is no justification for giving a high priority to the sovereign because it is sovereign. On the merits, indeed, there seems an unanswerable case for declining to prefer government claims, including claims on taxes, and giving priority to claims of greater social importance, such as the unearned premium reserve and, *a fortiori*, loss claims. The sovereign, and in particular the United States, will be able to survive without hardship even if relegated to the priority accorded ordinary creditors. Of course, governments as insureds stand on a different footing.

An insurer in liquidation is failing to perform its social role and is casting heavy burdens on segments of society that cannot afford to bear them. In such a case, the modest contribution made to the handling of a difficult situation by the government, if its taxes are subordinated, may have social utility vastly in excess of its costs to the public. Moreover, by undertaking to regulate insurance, government should be regarded as assuming at least to this limited extent an obligation of underwriting solvency. This is as true of the federal government as of the states, for the federal government has delegated the field to the states on the theory that the states can do it better. When they fail to do it at all, such government can not then fairly depend on sovereign powers to get a preference over other creditors. Instead they should take a subordinate position in the priority hierarchy.

A problem is created by the Federal Insolvency Act, 31 U.S.C. s. 191, which provides in part: "Whenever any person indebted to the United States is insolvent. . . the debts due to the United States shall be first satisfied. . ." If in a case that Act were held to override a priority system for insurance liquidation that subordinates government claims, it would then be possible and desirable to seek Congressional amendment of that act.

There is considerable reason to think that the Federal Act would not override this priority system. There are 2 alternative and independent arguments, either of which is enough, if successful, to subordinate the federal government claim.

The first is based on restrictive interpretations of the section by the United States Supreme Court that may prevent its application to insurance. This argument is simple. The Federal Insolvency Act has been held by the United States Supreme Court to apply, despite its broad language, in only 4 cases: the decedent's estate, voluntary assignment for benefit of creditors, attachment of the estate of an absent debtor, and the commission of an act of bankruptcy. Kennedy, "The Relative Priority of the Federal Government: The Pernicious Career of the Inchoate and General Lien," 63 *Yale Law Journal* 905, 906, n. 6 (1954). None of these 4 cases seem to comprehend an insurance liquidation. Moreover, it applies only on insolvency of the insurer, which may not have been shown. *United States v. Oklahoma*, 261 U.S. 253 (1923). See comment on s. 645.42 (4).

The 2nd argument is based on Public Law 15, s. 2 (b), which provides that "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, unless such Act specifically relates to the business of insurance. . ." This precludes application of 31 U.S.C. s. 191, which does not specifically relate to the business of insurance and therefore can not "invalidate, impair, or supersede" any state law regulating insurance. The priority system created by this section is a state law regulating insurance for it is part of a complex statute all of which regulates insurance. In fact, Congress exempted insurance companies from the operation of the Federal Bankruptcy Act in recognition of the fact that they are subject to a complete system of state regulation, which extends to the rules governing insolvency. A federal court (*In Re Supreme Lodge of the Masons Annuity*, 285 Fed. 180 (N.D. Ga. 1923)) in discussing the bankruptcy exemption of insurance, notes that:

"No reasons for making these exceptions were assigned by the committees of Congress, but they may be surmised to lie in the public or quasi-public nature of the business, involving other interests than those of creditors, in the desirability of unarrested operation, the completeness of state regulation, including provisions for insolvency, and the inappropriateness of bankruptcy machinery to their affairs."

The rationale of the bankruptcy exemption, as stated by the federal court, is affirmed in s. 645.01 (4) (f). That paragraph indicates that the purposes of this chapter include "Regulation of the insurance business by the impact of the law relating to delinquency procedures and substantive rules on the entire insurance business." The statement of purpose is not a mere assertion, for it is clear that insurance regulation in general, and this chapter in particular, including the section on priorities, is part and parcel of the regulatory structure, and has a real impact on the on-going insurance operation. It follows, therefore, that the Federal Insolvency Act cannot "invalidate, impair, or supersede" the priority system of this section.

It is true that *Langdeau v. United States*, 363 S.W. 2d 327 (Tex. Civ. App. 1962), which on its facts is on all fours with the situation contemplated in this subsection, holds that the state may not subordinate federal tax claims even to wage claims. The case is thus a clear—but not high—authority. At best it would be only persuasive authority, but it is not in the least persuasive. The court seems to rest its position on 2 points, neither of which is clearly articulated or persuasively put. First, the court seems to rely heavily on *United States v. Emory*, 314 U.S. 423 (1941) as making clear that 31 U.S.C. s. 191 applies to the case and establishes the federal tax priority. But unfortunately for that argument, the *Emory* case was not an insurance case and it was one in which an act of bankruptcy had been committed, thus bringing it within one of the classes of cases to which s. 191 has been held to apply. The court's 2nd point was that the Texas statute subordinating the federal tax was not a regulatory statute, but merely a priority established for creditors. The Texas court seems simply wrong on this point. *A fortiori* it would be wrong under this subsection, which is designed to have a regulatory impact. This chapter as a whole, and even this single subsection, is an integral part of the regulatory pattern. In fact, the supervision of the ailing insurance enterprise is not only regulation, but regulation of the greatest intensity. The obvious regulatory impact of this chapter is not limited to sick and dying insurers, either, but influences the entire operation of the industry.

For example, it seems very clear that the preference of loss claims to unearned premium claims will have a bearing on the way the business is conducted, and particularly on the way premiums are financed. Premium financing agencies would avoid financing premiums for shaky companies, thus changing their operating patterns. This is important and fruitful regulation. Every part of the priorities section has regulatory impact, and is designed to make the insurance institution work better. This priorities section thus gives the liquidator the statutory basis for contesting the federal priority. If despite the case outlined here, the U.S. Supreme Court decided otherwise, the federal statute should then be amended if possible. But there is little point in proposing amendment until its meaning as applied to this situation is tested in an authoritative tribunal. Designing the subsection as it is designed is in effect inviting a test case the first time enough money is involved to justify it.

This comment does not purport to be a brief for the test case, if one develops. But the chances of achieving the goal are excellent and it should be tried. Acquiescence in an unfair federal priority in liquidation cases would be anticipatory capitulation. Acquiescence by the federal government in this reasonable state priority system is possible, though perhaps not to be relied upon; it would eliminate the need for a test case.

(6) **JUDGMENTS.** Claims based solely on judgments. If a claimant files a claim and bases it both on the judgment and on the underlying facts, the claim shall be considered by the liquidator who shall give the judgment such weight as he deems appropriate. The claim as allowed shall receive the priority it would receive in the absence of the judgment. If the judgment is larger than the allowance on the underlying claim, the remaining portion of the judgment shall be treated as if it were a claim based solely on a judgment.

Comment on sub. (6): Whether or not recent judgments can be rendered invalid under other provisions of this chapter, they should always be suspect because of the likelihood of inadequate defense in the last days of the insurer. This priority is an effort to provide additional protection to the estate of the insurer against unwarranted depletion by such inadequately defended suits. Such judgments are questionable enough that they should not be given parity of treatment with better proved claims. If the claimant proves his claim in the statutory way he gets his normal priority.

(7) **INTEREST ON CLAIMS ALREADY PAID.** Interest at the legal rate compounded annually on all claims in the classes under subs. (1) to (6) from the date of the petition for liquidation or the date on which the claim becomes due, whichever is later, until the date on which the dividend is declared. The liquidator, with the approval of the court, may make reasonable classifications of claims for purposes of computing interest, may make approximate computations and may ignore certain classifications and time periods as de minimis.

Comment on sub. (7): Interest might well receive the priority given the underlying claim. Practical considerations urge postponement. At some point, however, interest should be allowed before paying the remaining funds to ownership claimants. Interest should also rank ahead of the very low priority claims that fall in the next class. Interest does present special problems unless the liquidator is using automated equipment. These problems necessitate separate treatment. Moreover, the liquidator has wide discretion, controlled by the court, to pay or ignore interest, or to estimate it.

(8) **MISCELLANEOUS SUBORDINATED CLAIMS.** The remaining claims or portions of claims not already paid, with interest as in sub. (7):

(a) The first \$50 of each claim in the classes under subs. (2) to (6) subordinated under this section;

(b) Claims under s. 645.63 (2);

(c) Claims subordinated by s. 645.90;

(d) Claims filed late;

(e) Portions of claims subordinated under sub. (5); and

(f) Claims or portions of claims payment of which is provided by other benefits or advantages recovered or recoverable by the claimant.

Comment on sub. (8): It will be a rare liquidation that will pay anything to the last few priorities, but only claims of little merit have been relegated to this class. Still they should rank above ownership claims.

(9) **PREFERRED OWNERSHIP CLAIMS.** Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with s. 201.13. Interest at the legal rate shall be added to each claim, as in subs. (7) and (8).

Comment on sub. (9): These claims are quasi-ownership claims, and rank close to the bottom by their own terms.

(10) PROPRIETARY CLAIMS. The claims of shareholders or other owners.

645.71 Introductory comment: This section prescribes a procedure to assure proper court records and the submission of lists of recommended claims to the court. Special treatment is accorded to claimants of investment values under life and annuity contracts, and to unearned premium claimants, since the insurer's records should make their submission of claims unnecessary.

The former Wisconsin insurance liquidation law, s. 200.08, prescribed no appropriate procedures. Especially in view of the fact that liquidation is not frequent enough to generate detailed case law, it is useful to spell out basic procedures in the statute rather than rely on sketchy and inadequate tradition.