

**WITHHOLDING OVERHEAD
AND PROFIT IS WRONG IF
INSURANCE COMPANIES ARE
TRYING TO ACT RIGHT**

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INTRODUCTION

A recurring issue following property damage losses in Florida has been whether an insurance company may withhold or refuse to pay overhead and profit associated with repair work not yet performed on a residential or commercial structure. Nothing in the insurance policy directly discusses the issue of overhead and profit, but many insurance carriers routinely withhold payment of overhead and profit following a loss. Obviously, policyholders and their representatives are not thrilled with the insurance company withholding monies believed owed and lawsuits have been filed regarding this issue.

This paper discusses the duties of property insurance carriers toward their insureds. Then, the paper analyzes the rationale and treatment of the overhead and profit issue by courts, as well as by state Departments of Insurance.

As a matter of disclosure, the author is a policyholder attorney and is actively involved in two class action lawsuits involving this issue.

I. INSURANCE COMPANIES SHOULD ANALYZE THE OVERHEAD AND PROFIT ISSUE IN THE CONTEXT OF THEIR OBLIGATION OF GOOD FAITH AND FAIR DEALING – ESPECIALLY WHEN CONSIDERING CLAIMS CONDUCT NOT SPECIFICALLY ADDRESSED IN THE INSURANCE POLICY

A. Florida First Party Insurance Policyholders Are Always Entitled To (and Carriers are Required to Provide) Good Faith and Ethical Claims Handling.

In 1982, the Florida Legislature passed legislation requiring insurance companies to act in good faith. Section 624.155, Fla. Stat., provides in pertinent part:

(1) Any person may bring a civil action against an insurer when such person is damaged:

(a) By a violation of any of the following provisions by the insurer:

1. §626.9541(1)(i)....

...

(b) By the commission of any of the following acts by the insurer:

1. Not attempting in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured and with due regard for her or his interests;

2. Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made; or

3. Except as to liability coverages, failing to promptly settle claims, when the obligation to settle a claim has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage....

The Unfair Trade Practices portion of this act, §626.9541(1)(i), Fla. Stat., defines, in pertinent part, the following as unfair methods of competition and unfair or deceptive acts or practices:

(i) Unfair Claim Settlement Practices –

1. Attempting to settle claims on the basis of an application, when serving as a binder or intended to become a part of the policy, or any other material document which was altered without notice to, or knowledge or consent of, the insured;
2. A material misrepresentation made to an insured or any other person having an interest in the proceeds payable under such contract or policy on less favorable terms than those provided in, and contemplated by, such contract or policy; or
3. Committing or performing with such frequency as to indicate a general business practice any of the following:
 - a) Failing to adopt and implement standards for the proper investigation of claims;
 - b) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;
 - c) Failing to acknowledge and act promptly upon communications with respect to claims;
 - d) Denying claims without conducting reasonable investigations based upon available information.
 - e) Failing to affirm or deny full or partial coverage of claims, and, as to partial coverage, the dollar amount or extent of coverage, or failing to provide a written statement that the claim is being investigated, upon the written request of the insured within 30 days after proof-of-loss statements have been completed.
 - f) Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a

claim or for the offer of a compromise settlement;

- g) Failing to promptly notify the insured of any additional information necessary for the processing of a claim; or
- h) Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

The legislative history of these provisions contains a January 25, 1982 Press Release, issued by the House Insurance Committee which notes the significance of this legislation:

A major change in the state's Insurance Code has been proposed to allow anyone to sue their insurance company when it violates the Code....

...To protect the insurance consumer, most states have passed statutes modeled after the National Association of Insurance Commissioners (NAIC) model legislation. The Act prohibits such diverse subjects as unfair competition, false advertising, and unfair claims settlement practices. However, the Florida Act is watered down and deficient in several areas adequately covered in the Model Act. For example, even though an insurance company is found to have committed an illegal practice, the Insurance Commissioner is required to prove that the company knew that it was doing the illegal act in order to prevail against the insurance company. In other cases, the Commissioner must prove that the company committed the act with such a frequency as to indicate a general business practice. These requirements make effective enforcement of the Act impossible....

Consequently, the approach taken by the Insurance Committee bill is to provide a civil remedy which may be pursued by any policyholder when he has been damaged by the actions of an insurance company which violate the Insurance Code. An insured who successfully sues an insurance company under this provision can recover the amount of damages he has suffered, together with his court costs and attorney's fees. So that an insurance consumer may utilize this provision for his own individual problem, the "business practice" aspect of the unfair claim practices law does

not have to be proved by the consumer. Additionally, a number of provisions which were in the model NAIC bill but were not enacted in Florida have been added to the unfair claim practices law including a prohibition against “not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.”...

By enacting §624.155, Fla. Stat., the Florida Legislature has extended the fiduciary obligation long imposed on liability insurers to bind all insurers; insurance companies now have a legal duty, independent of the contract, to handle the claims of all insureds in good faith. Michael K. Green, Comment, *The Other Insurance Crisis: Bad Faith Refusal To Pay First-Party Benefits*, 15 Fla. St. U.L. Rev. 521, 544 (1987).

B. Florida Regulatory Law Imposes a Requirement of Good Faith and Ethical Claims Conduct, by way of Florida Administrative Code Chapter 4-220, Requiring Insurance Companies to Provide Fair, Honest, Prompt, Truthful and Ethical Treatment to Policyholders.

Insurance adjusters in the State of Florida are required to be licensed, and they must follow the rules set forth in the Florida Administrative Code as follows:

4-220.201 Ethical Requirements.

...

(4) Code of Ethics. The following code of ethics shall be binding on all adjusters.

(a) The work of adjusting insurance claims engages the public trust. An adjuster must put the duty for fair and honest treatment of the claimant above the adjuster’s own interests, in every instance.

(b) An adjuster shall have no undisclosed financial interest in any direct or indirect aspect of an adjusting transaction....

(c) An adjuster shall treat all claimants equally; an adjuster shall not provide favored treatment to any claimant. An adjuster shall adjust all claims strictly in accordance with the insurance contract.

...

(f) No adjuster may advise a claimant to refrain from seeking legal advice, nor advise against the retention of counsel to protect the claimant's interest.

....

(i) An adjuster shall not knowingly fail to advise a claimant of their claim rights in accordance with the terms and conditions of the contract and of the applicable laws of this state....

(j) An adjuster shall approach investigations, adjustments, and settlements with an unprejudiced and open mind.

(k) An adjuster shall make truthful and unbiased reports of the facts after making a complete investigation.

(l) An adjuster shall handle each and every adjustment and settlement with honesty and integrity and allow a fair adjustment or settlement to all parties without any remuneration to himself except that to which he is legally entitled.

(m) An adjuster, upon undertaking the handling of a claim, shall act with dispatch and due diligence in achieving a proper disposition thereof.

(n) An adjuster shall not undertake the adjustment of any claim concerning which the adjuster is not currently competent and knowledgeable as to the terms and conditions of the insurance coverage, or which otherwise exceeds the adjuster's current expertise.

...

C. The Insurance Industry Recognizes that it has a Special Relationship with Policyholders and the Obligation of Good Faith and Ethical Claims Conduct.

Respectfully, for the same reason one would not expect to learn medicine by reading malpractice cases, no person can expect to learn how adjusters are taught to treat policyholders by only reading bad faith case law. Claims representatives are taught honest and honorable ways to handle claims. The standard textbook for claims handlers, which leads to an Associate in Claims designation, is James J. Markham, et al., *The*

Claims Environment (1st ed., Insurance Institute of America 1993). There is now a second edition of *The Claims Environment*.¹

The Markham textbook for claims handlers and students of insurance sets forth simple, clear claims handling principles. Some of these principles are:

“Claims representatives....are the people responsible for fulfilling the insurance company’s promise.”

Markham at vii.

“When a covered loss occurs, the insurance company’s obligation under its promise to pay is triggered. The claim function should ensure the prompt, fair, and efficient delivery of this promise.”

Markham at 6.

“Therefore, the claim representative’s chief task is to seek and find coverage, not to seek and find coverage controversies or to deny or dispute claims.”

Markham at 13.

“...the insurance company should not place its interests above the insured’s.”

Markham at 13.

“The claim professional handling claims should honor the company’s obligations under the implied covenant of good faith and fair dealings.”

Markham at 13.

“No honest and reputable insurer has either explicit or implicit “standing orders” to its claim department to delay or underpay claims.”

Markham at 274.

“When an insurance company fails to pay claims it owes or engages in other wrongful practices, contractual damages are

¹ Doris Hoopes, *The Claims Environment*, (2d ed., Insurance Institute of America 2000).

inadequate. It is hardly a penalty to require an insurer to pay the insured what it owed all along.”

Markham at 277.

“All insurance contracts contain a covenant of good faith and fair dealing.”

Markham at 277.

“If bad faith is a tort in a third-party claim, it should be a tort in a first-party claim as well.”

Markham at 277.

“Insurance is a matter of public interest and deserves special consideration by the courts to protect the public.”

Markham at 277.

“Insurance contracts are not like other contracts because insurers have an advantage in bargaining power. Insurers should therefore be held to a higher standard of care.”

Markham at 277.

“Recovery for breach of an insurance contract should not be limited to payment of the original claim.”

Markham at 277.

“The public’s expectations are elevated by insurers’ advertising, slogans, and promises which give policyholders the impressions that they will be taken care of no matter what happens.”

Markham at 277.

“Policyholders buy peace of mind and are not seeking commercial advantage when they buy a policy. In addition, they are vulnerable at the time of the loss.”

Markham at 277.

“Policy language is sometimes difficult to understand. The benefit of interpretation should be given to the policyholder.”

Markham at 277-278.

“Upper management also has a responsibility to maintain proper claim-handling standards and practices.”

Markham at 300.

The Second Edition of *The Claims Environment* explains, in part, various aspects of good faith claims handling:

Unbiased Investigation

Claim representatives should investigate in an unbiased way, pursuing all relevant evidence, especially that which establishes the legitimacy of a claim. Claim representatives should avoid using leading questions that might slant the answers. In addition, they should work with service providers that are unbiased. As mentioned previously, courts and juries might not look sympathetically on medical providers or repair facilities that favor insurers. Investigations should seek to discover the facts and consider all sides of the story. Claim representatives should not appear to be looking for a way out of the claim or for evidence to support only one side.

Prompt Evaluation

As described in Chapter 9, unfair claims settlement practices acts often specify time limits within which to complete evaluations of coverage and damages. Claim representatives should be sure to comply with those requirements to reduce their exposure to bad faith claims.

Doris Hoopes, *The Claims Environment* 10.7 (2d ed., Insurance Institute of America 2000).

It is important to note that there are professional designations in the insurance trade. One group of insurance professionals is the Society of Chartered Property and Casualty Underwriters (CPCU). An individual becomes a CPCU after a course of professional study, passing an examination, and making a professional commitment. To

attain professional status, a CPCU must agree to abide by the CPCU Code of Professional Ethics and take this lofty professional oath:

I shall strive at all times to live by the highest standards of professional conduct; I shall strive to ascertain and understand the needs of others and place their interests above my own; and shall strive to maintain and uphold a standard of honor and integrity that will reflect credit on my profession and on the CPCU designation.

The CPCU Professional Commitment, *AICPCU/IIA Catalog*, 1999-2000, at 66.

The CPCU Code of Professional Ethics is generally known, accepted, and followed within the insurance trade. The standards the Code sets forth are established standards. The Canons from the Code of Professional Ethics of the American Institute for the CPCU are:

- CANON 1: CPCUs should endeavor at all times to place the public interest above their own.
- CANON 2: CPCUs should seek continually to maintain and improve their professional knowledge, skills and competence.
- CANON 3: CPCUs should obey all laws and regulations; and should avoid any conduct or activity which would cause unjust harm to others.
- CANON 4: CPCUs should be diligent in the performance of their occupational duties and should continually strive to improve the functioning of the insurance mechanism.
- CANON 5: CPCUs should assist in maintaining and raising professional standards in the insurance business.
- CANON 6: CPCUs should strive to establish and maintain dignified and honorable relationships with those whom they serve, with fellow insurance practitioners, and with members of other professions.

CANON 7: CPCUs should assist in improving the public understanding of insurance and risk management.

CANON 8: CPCUs should honor the integrity of the CPCU designation and respect the limitations placed on its use.

CANON 9: CPCUs should assist in maintaining the integrity of the Code of Professional Ethics.

David H. Brownell & Stephen Herald, *Ethics in the Insurance Industry: A Case Study Approach* 6-7 (Am. Inst. For Chartered Prop. Cas. Underwriters Ins. Inst. Of Am.).

Insurance companies employ most of the nation's CPCUs. Insurance companies should not be exempt from established trade customs, trade standards, and trade usage simply because not all of their employees are CPCUs, nor because only individuals and not insurance companies can earn the professional degree. There are more than 30,000 members of the CPCU Society. See <http://www.aicpcu.org/mediacenter/history.html>.

In 1973, the Supreme Court of California decided *Gruenberg v. Aetna Insurance Co.*, 510 P.2d 1032 (Cal. 1973), which first found that an implied covenant of good faith and fair dealing was owed by an insurer to its policyholder, such that the breach would give rise to a bad faith claim in tort. Known as "first-party bad faith", this tort allowed insurance claimants to collect extra-contractual damages for an insurer's bad faith refusal to pay an insurance claim.

After 1973, at least twenty-five other states have adopted this new tort. Dominick C. Capozzola, Note, *First-Party Bad Faith: The Search for a Uniform Standard of Culpability*, 52 Hastings L.J. 181, 182 (2000). See also Stephen S. Ashley, *Bad-Faith Actions: Liability and Damages* 2-54 (2d. ed., West Group 1997) ("A substantial minority of jurisdictions have rejected a common-law tort cause of action for bad-faith in first-

party cases."). Professor Ashley notes that every state, except Florida, Georgia, Illinois, Kansas, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, New York, Oregon, Pennsylvania and Tennessee recognize first-party bad-faith at common law based on either a tort or contract theory. *See id.* at 2-54-55. *See generally* Roger C. Henderson, *The Tort of Bad-Faith in First-Party Insurance Transactions After Two Decades*, 37 Ariz. L. Rev. 1153, 1156 (1995)(noting that since *Gruenberg*, over thirty jurisdictions recognize remedies for first party insurer misconduct when private statutory remedies are considered).

The significance of these decisions is that the majority of states recognize the very special and fiduciary relationship owed by insurance companies to policyholders. The insurance industry, sister courts, consumer advocates, the Florida Department of Insurance and the Florida legislature recognize and acknowledge that a special duty is owed by an insurance company to its policyholder, and the duty involves more than the typical commercial relationship.

A particularly scholarly discussion explaining why insurance is treated differently by courts is found in an article written by Professor Henderson of the University of Arizona College of Law, which includes the following discussion:

In a free enterprise system, economic development steadily increases the number of situations in which individuals can suffer "loss." At the same time, economic development enhances the ability to avoid the prospect of "loss." In other words, in a relatively affluent society, there is much more to lose in the way of property and other economic interests as the human condition improves. In such a society, however, individuals are more likely to have the requisite discretionary income to transfer and to spread the attendant risks of loss. Disruptive losses to society, as well as to the individual, are obviated or minimized by private agreements among similarly situated people. In this way, the insurance industry plays a very important institutional role by providing the

level of predictability requisite for the planning and execution that leads to further development. Without effective planning and execution, a society cannot progress.

....

This perceived social significance has set apart insurance contracts from most other contracts in the eyes of the law. Insurance is purchased routinely and has become pervasive in our society. It protects against losses that otherwise would disrupt our lives, individually and collectively. The public interest, as well as the individual interests of millions of insureds, is at stake. This is the foundation for the general judicial conclusion that the business of insurance is cloaked with a public purpose or interest. This perception also explains the extensive regulation of the insurance industry in the United States, not just through legislative and administrative processes, but also through the judicial process. In fact, as with developments in other areas of tort law, the recognition of the tort of bad faith in insurance cases represents a judicial response to the perceived failure of the other branches of government to regulate adequately the claims processes of the insurance industry. Had the early attempts at regulation been more effective, the tort of bad faith might never have come into existence.

...

The insureds' disadvantage persisted as insurance took on more and more importance in this country. In order to purchase a home or a car, or commercial property, most people had to borrow money, and loans were not obtainable unless the property was insured. In addition, the lender often required that the life of the borrower be insured. On another front, the cost of medical care was rising beyond the reach of many people and insurance programs were developed to spread that risk. The purchase of insurance was no longer a matter of prudence; it was a necessity. Then losses occurred and the inevitable disputes arose. These disputes, however, were not about an even exchange in value. Rather, they were about something quite different.

Insureds bought insurance to avoid the possibility of unaffordable losses, but all too often they found themselves embroiled in an argument over that very possibility. Disputes over the allocation of the underlying loss worsened the insureds' predicament. In most instances, insureds were seriously disadvantaged because of the uncompensated loss; after all, the insured would not have insured against this peril unless it presented a serious risk of disruption in the first place. The prospect of paying attorneys' fees and other

litigation expenses, in addition to the burden of collecting from the insurer, with no assurance of recovery, only aggravated the situation.

These additional expenses could prove to be a formidable deterrent to the average insured. For most insureds, unlike insurers, such expenses were not an anticipated cost of doing business. Insureds did not plan for litigation as an institutional litigant would. Insurers, on the other hand, built the anticipated costs of litigation into the premium rate structure. In effect, insureds, by paying premiums, financed the insurers' ability to resist claims. Insureds, as a group, were therefore peculiarly vulnerable to insurers who, as a group, were inclined to pay nothing if they could get away with it, and, in any event, to pay as little as possible. Insurance had become big business.

Roger C. Henderson, *The Tort of Bad Faith in First-Party Insurance Transaction: Refining the Standard of Culpability and Reformulating the Remedies By Statute*, 26 U. Mich. J.L. Ref. 1, 10-14 (1992).

The man on the street knows that it is far more profitable for an insurance company to take a person's money and not pay, rather than to promptly and fully pay what is owed. That this financial incentive conflicts with the extreme public trust placed in the insurance industry is the reason why codes of ethics, good faith duties and common law remedies are imposed upon insurers. Public policy demands that any analysis and consideration to pay or not pay a policyholder be made under these guidelines and an insurer cannot mistreat its policyholder.

Insurers must analyze the overhead and profit issue in this context.

II. THE ORIGIN OF THE OVERHEAD AND PROFIT ISSUE

From the best information available, the first insurance company to withhold contractor overhead and profit was State Farm Fire & Casualty Insurance Company. A claims manager, Tony Prosperini, has been deposed in a number of actions involving this issue. See Depositions of Tony Prosperini in *Aita v. State Farm Fire & Cas.*, Superior Court of N.J., Middlesex Cty. (1995), Case No. L-12024-95, taken April 15, 1998; *Gonzalez v. State Farm*, Superior Court of California, Los Angeles County; Case No. 4:97-CV-832-4; taken December 4, 1997; *Harrington v. State Farm Lloyds, Inc.*, U.S.D.C., N.D. Case No. 4:97-CV-832-4. Indeed, the first and only case which has ever indicated that an insurance company may withhold overhead and profit is a State Farm case, *Snellen v. State Farm Fire & Cas. Co.*, 675 F.Supp. 1064 (W.D. Ky. 1987).

The basic argument made by State Farm is that under a replacement cost insurance policy, the total amount payable for replacement of a structure is not paid until the insured actually incurs an expense of replacement. Since a general contractor's overhead and profit is an expense of repair or replacement which is not incurred until it is paid, the insurance carrier under a replacement cost policy is entitled to withhold those portions of adjusted loss until the insured actually expends money for that item. Prosperini has also testified that no overhead and profit should be paid if the work is not to be performed by a general contractor.

Snellen approved of State Farm settling and paying "actual cash value" by determining the total replacement cost and then subtracting overhead and profit. In *Snellen*, the fire damaged home was covered by replacement cost insurance. No repairs

were actually undertaken on the property. Thus, the policy limited the insured's recovery to "actual cash value." The total amount withheld by State Farm included the general contractor's overhead and profit, permits, and depreciation. The *Snellen* court found that State Farm's method of calculation was appropriate under Kentucky's "Broad Evidence Rule" for determining actual cash value stating:

Since the goal is to arrive at the actual cash value of the damage, non-damage factors, which are applicable only in the instance of repair or replacement such as clean up, profit, overhead and permits, were properly deducted. These factors have no relation to the value of the damage but only the expense, which would be incurred if repair or replacement were involved.

Ronald Reitz, an insurance defense attorney, commented that the *Snellen* court's reasoning suggests that "Actual Cash Value" does not include "non-damage factors" that have not actually been incurred. R. Reitz, *Overhead & Profit: Can They Be Deducted in ACV Settlements?*, *Claims Magazine* 64, 65 (Aug. 2000).

Subsequently, the Kentucky Department of Insurance found this conduct and type of adjustment inappropriate. Most adjusters are not aware that the Kentucky Department of Insurance subjected Allstate Insurance Company to a market conduct examination regarding this very issue, and found Allstate's actions of withholding overhead and profit to be improper. *See Kentucky Market Conduct Examination of Allstate Insurance Company*, August 4, 1993 and Order dated December 8, 1994. Accordingly, while insurers may be able to point to published case law from Kentucky as support for withholding overhead and profit, they do so at the peril of knowing that the Kentucky of Insurance has found the same policy violates public policy.

III. HOW THE ISSUE OF OVERHEAD AND PROFIT AROSE IN FLORIDA

Following the 1987 *Snellen* decision, many other carriers started to withhold overhead and profit as a matter of routine claims practice. Hurricane Andrew brought the matter to the Florida Department of Insurance's attention after a number of consumers complained that insurers were not paying the full amount of estimated damage. The Florida Department of Insurance issued Bulletin 92-036 on December 8, 1992, which reads as follows:

The payment of a partial loss on real property must be handled in a manner consistent with existing statutes and case law.

Section 627.702(2) Florida Statutes, while specifying only fire and lightning losses, is instructive in discerning legislative intent in applying the Valued Policy Law to partial losses on real estate resulting from Hurricane Andrew. This statute provides that the insured is entitled to the "actual amount of such loss", not to exceed the amount of insurance specified in the policy as to such property.

The Florida Supreme Court, in *Sperling v. Liberty Mutual*, So.2d 297 (Fla. 1973), held that the "actual amount of such loss" is the cost of placing the building in as nearly as possible the same condition that it was before the loss, without allowing depreciation for the materials used.

This authority is specifically applicable to the practice by insurers of imposing a "holdback" of insurance proceeds greater than actual cash value until replacement has taken place. While this practice is appropriate for personal property, this bulletin serves to place insurers on notice that for partial losses on real property, the "holdback" is inconsistent with established precedent.

The application of a "holdback" to repair of real property can particularly cause hardship to the insured when the actual cash value payment is insufficient to enter into a contract to make repairs. In such an instance,

the insured may be forced to seek other funding sources, at his expense, in order to contract for repairs.

Insurers who have been applying “holdbacks” in claims for partial loss on real property should pay the actual amount of the loss. The best indicator of actual loss is the contract for repair entered into by the insured. Once an actual amount of loss is determined by contract, the full loss payment should be made with no hold back applied. This arrangement satisfies the public policy interests both in timely and sufficient claim payments, and in encouraging rebuilding. In instances where a holdback is currently being applied and a repair contract has been executed, the holdback should be released.

While the title clearly indicates that “hold backs” of any type less than the full replacement cost is “prohibited,” the insurance industry has since relied upon language found in the last paragraph to continue the practice. Adjusters indicated that they would “hold back” various aspects of the full replacement or repair estimate, unless the policyholder signed a construction contract with a general contractor. Accordingly, the debate regarding whether insurance companies are wrongfully withholding overhead and profit continued.

At the time the Florida Department of Insurance issued its bulletin in 1992, existing case law in this state seemed to indicate that the policyholder was entitled to the full amount of the estimated repair or replacement cost or an actual cash value adjustment.

The Florida Supreme Court held that, when considering the amount of a property loss, “the property should have been placed in as nearly as possible the same condition that it was before the loss, without allowing depreciation for the materials used.” *Glen Falls Ins. Co. v. Gulf Breeze Cottages*, 38 So.2d 828,830 (Fla. 1949).

The court reaffirmed this rule in *Sperling v. Liberty Mutual Insurance Company*, 281 So. 2d 297 (Fla. 1973). The *Sperling* court held the “actual amount” of any partial loss was determined without allowing depreciation. 281 So.2d at 298. Atlantic Mutual attempted to distinguish *Sperling* by arguing it involved the Valued Policy Law, §627.702, Fla. Stat.

Section 627.702(2), Fla. Stat., provides that “in the case of a partial loss by fire or lightning of any such property [a building, structure, etc], the insurer’s liability, if any, under the policy shall be for the actual amount of such loss but shall not exceed the amount of insurance specified in the policy as to such property and such peril.” That a partial loss by fire triggers this statute is immaterial to the discussion of how to determine the “actual amount” of a loss discussed in *Sperling* or *Glens Falls*.

The valued policy statute merely provided the reason the court looked at the actual amount of the loss in *Sperling*. The importance of *Sperling* is that it recognizes the actual amount should not be reduced by depreciation. That holding follows from *Glens Falls*, a case that nowhere cited the valued policy statute.

Florida cases also hold that Florida adheres to the “Broad Evidence Rule,” whereby the trier of fact can consider any evidence logically tending to establish a correct estimate of the value of the damaged property to determine actual cash value. This includes replacement cost, even though not synonymous with actual cash value. See *New York Cent. Mut. Fire Ins. Co. v. Diaks*, 69 So. 2d 786 (Fla. 1954); *Worcester Mutual Fire Insurance Company v. Eisenberg*, 147 So.2d 575, 576, (Fla. 3d DCA 1962).

IV. ALL OTHER CASES, INCLUDING A FLORIDA CASE, ADDRESSING THE ISSUE OF OVERHEAD AND PROFIT HAVE FOUND THAT THE INSURANCE COMPANY IS NOT ENTITLED TO DEDUCT OVERHEAD AND PROFIT

In *Gilderman v. State Farm Ins. Co.*, 649 A.2d 941 (Pa. Super. 1994), *alloc. den.*, 661 A.2d 874 (Pa. 1985), the court held that the repair or replacement cost includes any amounts that an insured is reasonably likely to incur in repairing or replacing a covered loss. It found that, in some instances, those costs include use of a general contractor and a 20% overhead and profit charge. The *Gilderman* court's reasoning indicated that the cost of building materials, whether or not such materials are actually purchased, and the cost of labor to install or make such repairs of the materials is to be considered. It further went on to hold that, under Pennsylvania law, where replacement costs are reasonably likely to be incurred, no deductions may be made to determine Actual Cash Value, such as where the insured is a plumber and does his own repair work.

Insurance companies continue to argue that *Gilderman* does not require that such costs must always be included in Actual Cash Value settlements. Instead, those companies' adjusters claim *Gilderman* stands for the proposition that overhead and profit costs may only be included where they are "reasonably likely" to be incurred by the insured.

Following *Gilderman*, in 1998 the Michigan Court of Appeal decided

Salesin v. State Farm Fire & Cas Co., 581 N.W. 2d 781 (1998 Mich.App.), *app. den.*, 615 N.W. 2d 738 (Mich. 1998), and held that State Farm owed the policyholder for general contractor overhead and profit, despite the fact that the policyholder would “almost certainly” not incur that expense. *Salesin* involved a water loss to a residential house caused by a leaking washing machine hose. The policyholder asserted that State Farm wrongfully withheld \$5,581.79 in general contractor profit and overhead when adjusting the loss. The policy at issue was State Farm’s “HO5 Replacement Cost Policy” which has provisions allowing for holdback of “depreciation” and the policy, like most insurance policies, does not directly address the terms of contractor overhead and profit.

The *Salesin* Court stated:

It is uncomfortably true that finding that State Farm owes Salesin an additional \$5,581.79 for contractors’ overhead and profit will result in a payment to him for costs that he has not incurred and almost certainly will not incur. However, it is true Salesin has paid a premium for a full replacement cost policy. There is no logical reason, nor any reason based on the insurance policy itself or the record below, for deducting estimated contractor’s overhead and profit when making payments under §I.c.(1) of State Farm’s insurance policy...[T]he reasoning in *Gilderman* is, we believe, superior to the reasoning in *Snellen*.

Id. at 369.

Salesin has a few unreported footnotes which are important to Florida policyholders. First, the discovery in the case forced State Farm to turn over a number of its operational guidelines. Operation Guides are State Farm’s claims process and procedure manuals. In these guides, State Farm admitted that its claims adjusters were to pay for a policyholder’s own labor and expenses when considering the amount payable under the policy. Second, in its briefs before the Appellate Courts of Michigan, State Farm admitted that a policyholder is entitled to the expense of its own labor incurred if

the policyholder rebuilds property himself rather, than hiring an outside contractor or vendor.

The reason the aforementioned is important in Florida is because State Farm wrongfully argued a different proposition and won, without disclosing to the Florida appellate court that its own Operation Guides require such payment in *State Farm Fire & Cas. Co. v. Patrick*, 647 So.2d 983 (Fla. 3d DCA 1999).

A recent federal district court decision in *Ghoman v. New Hampshire Ins. Co.*, 159 F. Supp. 2d 928 (N.D. Tex. 2001), further supports the position that insurance companies cannot deduct general contractor overhead and profit under any circumstances. In *Ghoman*, a commercial hotel was badly damaged by wind and hail. The parties went to appraisal, and the appraisal award valued the replacement cost at \$299,907 and the Actual Cash Value award was \$262,353. New Hampshire Insurance Company then offered an amount less than the appraisal award for Actual Cash Value, by deducting depreciation, contractor's overhead and profit and sales tax. The policyholder contended that except for depreciation and the deductible, the items were wrongfully withheld, and that he should be entitled to the amount of the Actual Cash Value award.

The insurance company argued that the policyholder was paid more than what he spent to repair the property, and that the plaintiff made a replacement cost claim rather than an Actual Cash Value claim. The *Ghoman* court noted that the policy allowed the policyholder to either make a claim for replacement cost for Actual Cash Value supplemented by additional replacement cost coverage. *Id* at 933. According to the court noted that "the mere fact that plaintiff may have requested funds to repair or replace ... is not inconsistent with making an Actual Cash Value claim." The *Ghoman* court explained

that the purpose of the replacement costs provisions “is to enable the insured to obtain funds to begin the process of repair or replacement, at which point the insured could submit claims for expenditures that went above the Actual Cash Value of the loss.” *Id.* Thus, an insured who initially seeks replacement cost may still file an Actual Cash Value claim. *Id.*

Relying upon *Salesin* and *Gilderman*, the *Ghoman* court held that “repair or replacement costs include any costs an insured is reasonably likely to incur in repairing or replacing a covered loss....Contractor’s overhead and profit and sales tax clearly fit this definition. These amounts should be included in the Actual Cash Value award. *Id.* at 934. The *Ghoman* court also held that the insurance company breached the policy by unilaterally deducting those sums from the appraisal award and explained that:

.....the policy in this case entitles plaintiff to recover the actual cash value of his loss whether or not he repaired the damaged property. *See also Harrington v. Amica Mutual Insurance Co.*, 223 A.D. 2d 222, 226, 645 N.Y.S. 2d 221, 223 (N.Y. App. Div. 1996) (“Plaintiff would have been entitled to recover the actual cash value from defendant even if a third party had completed the repairs at no cost to plaintiff.”) What plaintiff actually spent to repair his property—indeed, whether he repaired the property at all – does not affect his right to recover actual cash value. The fact that plaintiff was able to complete the repairs for less than the appraisal award does not result in a windfall. Plaintiff was covered for the actual cash value of his loss and is entitled to recover that sum, less his deductible.

The only Florida case addressing the issue arguably finds that an insurance company may not deduct a general contractor’s overhead and profit. The case is *Bankers Security Ins. Co. v. Brady*, 765 So.2d 870 (Fla. 5th DCA 2000). In *Brady*, a fire and lightning strike damaged a home insured by Bankers. Bankers’ independent adjuster and the Brady’s Public Adjuster orally agreed that the total loss was \$65,000.00. *Id.* at 871.

When Bankers reneged on this agreement, Brady sued Bankers, alleging breach of the oral settlement agreement. Brady argued that the insurance company breached the policy by failing to pay the full agreed upon amount, and by withholding a contractor's overhead and profit. Brady claimed that he did much of the repair work on his home himself causing him to miss work and lose his personal time.

The Court found the oral agreement as a binding settlement for \$65,000.00 and stated the following:

Having concluded there was a binding settlement reached for \$65,000.00, we need not address the additional issue of whether Bankers could withhold overhead and profit. It apparently has paid the settlement reached by Shea, less overhead and profit. But we find nothing in the policy that authorizes Bankers to withhold overhead and profit from the cost to repair or replace a covered loss, since under this policy Bankers undertook to pay its insured prior to actual repair or replacement.

Id. at 872.

V. TEXAS AND COLORADO DEPARTMENTS OF INSURANCE HAVE FOUND WITHHOLDING OF GENERAL CONTRACTOR OVERHEAD AND PROFIT IMPROPER

On June 12, 1998, the Texas Department of Insurance issued Bulletin #B-0045 98, indicating that the deduction of a prospective contractor's overhead and profit and sales tax, in determining the actual cash value under a replacement cost policy, is improper. The Department noted that the wrongful interpretation of language in the Texas Standard Homeowner's Policy generated two class action lawsuits and various inquiries to the Department's position on the matter.

In explaining its reasoning, the Department noted that “there is no situation in which the deduction from replacement cost of depreciation and contractor’s overhead and profit and/or sales tax on materials will be the correct measure of the insured’s loss.” Further, the Department noted that insurance companies are not allowed to charge premiums in excess of the risk to which they apply. Thus, under a replacement cost policy, the value of the contractor’s overhead and profit, as well as sales tax on building materials, are included in the premium, and if the insurer receives a premium on insurable values which loss may never be paid, “the insurer reaps an illegal windfall.”

Finally, the Department dispensed with the common argument that contractor’s overhead and profit, as well as sales tax on building materials, should be excluded from Actual Cash Value settlements because the insured has not incurred these expenses as illogical:

Using this logic, an insured who opts not to repair or replace damaged property would not incur any of the expenses necessary to repair or replace the damaged property, including the costs of building materials, and would collect nothing under an actual cash value loss settlement. This result would be contrary to the purposes of the subject insurance policy.

The Colorado Department of Insurance issued 12-98 on December 21, 1998, prohibiting the deduction of a contractor’s overhead and profit from replacement costs where repairs are not made. The Department stated:

The position of the Division of Insurance is that the actual cash value of a structure under a replacement cost policy, when the policyholder does not repair or replace the structure, is the full replacement cost with proper deduction for depreciation. Deduction of contractor’s overhead and profit, in addition to depreciation, is not consistent with the definition of actual cash value.

CONCLUSION

Policyholders expect full and prompt payment to their property following losses. Insurance companies sell products which are significantly indistinguishable from one another. The only value to those products is the fact that insurance companies will honor the promises made to their policyholders, so that full and prompt payment occurs. Unfortunately, because of a number of improper claims occurrences and the inherent profitability of not paying fully the amount owed in a prompt manner, the law has imposed significant fiduciary-like obligations upon insurance companies when handling insurance claims.

When addressing the issue of overhead and profit holdbacks from the standpoint of good faith claims conduct, it can hardly be said that insurance companies, currently conducting such practice, are doing so with specific contract authority and in good faith. Nowhere do these policies state that the insurance company has the right to withhold the contractor overhead and profit under either a replacement cost or Actual Cash Value basis. No insurance company advertisements warn potential customers that they can expect something less than complete repair estimate payments following a catastrophe.

Indeed, the promise of full and prompt payment is completely destroyed when some carriers wrongfully make claims profits by not following what is the obvious law on the matter. Those companies who continue to wrongfully profit, by withholding monies due to their policyholders, can expect to be sued for their unjust enrichment as suggested by the Texas Department of Insurance, and for their violation of the Florida Unfair Claim and Trade Practice statutes.

