provided coverage for compensatory damages and for the award of costs, but that the insurer had no obligation to pay the attorney fee award based on wage and hour claims for which the policies provided no coverage. Both parties appealed.

The Second District Court of Appeal affirmed in part and reversed in part. The trial court properly found that the insurer was not obligated to pay the attorney fee award. The policies at issue included "supplemental payments" provisions that promise to pay costs awarded against the insureds only if the insurer had a duty to defend the insureds. The duty to defend, however, arises only for those claims for which there is at least potential coverage under the policy. Thus, the insurer has no obligation to pay costs arising solely from claims that were not even potentially covered under one or both of the policies. Mintarsih conceded that the policies do not cover her wage and hour claims, and her statutory right to recover attorney fees was based solely on these claims. The trial court erred, however, in finding that the insurer had a duty to indemnify the insureds for the compensatory damages award for false imprisonment and negligence because an insurer has no duty to indemnify a loss caused by the insured's willful act. See Ins C §533. The jury verdict established that the insureds's misconduct was willful for the purposes of §533, *i.e.,* the deprivation of Mintarsih's freedom for purposes of exploiting her as a domestic servant while depriving her of the wages and breaks to which she was entitled was inherently harmful. The insureds' negligent conduct was "intimately connected with their intentional misconduct," so as to constitute the same course of conduct for purposes of §533. Because the insurer has no duty to indemnify under either policy for the damages awarded against the insureds, it has no obligation to pay postjudgment interest on the judgment awarded against them.

***COMMENT:*** This is a rare example of a court interpreting an insurance policy to say that it does not provide the benefit that the policy clearly seems to provide. Nonetheless, it is difficult to fault the court's reasoning.

The policy provided that supplemental benefits in the form of attorney fees and costs were payable for claims that the company defended. Yet, in this case, these fees and costs were clearly payable only under causes of action for which there was no coverage. Because there was a covered claim, the insurer was obligated to defend the entire action. *Buss v Superior Court* (1997) 16 C4th 35, 48, 65 CR2d 366. However, the insurer had the right to obtain reimbursement from the insured for defense costs solely attributable to the defense of noncovered claims. 16 C4th at 50. Under these circumstances, the court held that it was not within the intention of the parties when the policy was issued that expenses clearly attributable to noncovered claims would be covered.—*Arnold R. Levinson*

### *Policy Interpretation*

**Trial court properly applied unambiguous definition of "occurrence" as stated in policy.**

*Supervalu, Inc. v Wexford Underwriting Managers, Inc.* (2009) 175 CA4th 64, ___ CR3d ___

The insurers provided the insured with excess workers' compensation insurance under which the insured's self-insured retention for each occurrence was $500,000. The policies provided that indemnity coverage was subject to the insurer's maximum limit of liability for loss arising out of any one "occurrence" of $1,000,000 in excess of the insured's retention. The policies defined "occurrence," as applied to bodily injury, to "mean accident"; an employee's occupational disease was deemed to be a separate occurrence occurring on the last date of the employee's exposure to the deleterious work conditions. At issue in this declaratory relief action brought by the insured is the interpretation of the word "occurrence" as used in the policies. The trial court agreed with the insurer that there was an "occurrence," and thus the insured was required to pay a self-insured retention, whenever an employee sustained injury due to an accident or occupational disease. On appeal, the insured argued that, in the workers' compensation industry, "occurrence" means a claim that results in one award or compromise and release regardless of the number of injuries involved, and that this technical meaning controls interpretation of the policies.

The Second District Court of Appeal affirmed. The contract language governs its interpretation "if the language is clear and explicit and does not involve an absurdity." See CC §§1638, 1639. Here, the policy language is neither patently nor latently ambiguous; rather, it is clear and explicit and does not involve an absurdity. The policy language unambiguously suggests that an occurrence involves either an accident or cumulative injuries. The definition of occurrence does not distinguish between situations in which single employees or multiple employees are injured, because an occurrence is an event—either an accident or occupational disease. As to an accident, the number of employees injured is irrelevant, *i.e.,* it could be one or many employees and it would still be one occurrence. In contrast, there are as many occurrences as there are employees who suffer occupational disease.

***COMMENT:*** Periodically, an insurer adopts an interpretation of the policy and pays benefits that the policy does not actually provide. When it discovers the error, it informs the usually surprised insured that benefits that were previously being paid will no longer be paid. The natural reaction is to claim waiver or estoppel or that the insurer's past interpretation establishes that the policy is, at a minimum, ambiguous, and thus it must be interpreted as the insurer has been doing for a long time.

When presented with such a situation, the first thing to assess is whether, in fact, the insured has been receiving benefits that truly were not covered. If so, it may not be so wise to sue the insurer. As this court explains, waiver and estoppel do not apply unless the insured has relied to

its detriment on the insurer's actions. Here, there was no such evidence. The insured would need to allege that, but for the insurer's actions, the insured would have either acted differently or obtained other insurance. Before making such an allegation, the insured should check to see if the benefits the insurer is now refusing to pay were available from other insurers.

The other argument, that the policy should be interpreted in the insured's favor, might fail if the court finds the language of the policy and/or prior case law to unambiguously state that there is no coverage. The risk of instituting suit when these arguments for coverage fail is that the insurer will counterclaim against the insured to get back benefits it wrongfully paid in the past. Every once in a while, it might be prudent to chalk up an insurer's past activities as an unintended "gift" and move on.—*Arnold R. Levinson*

## Tort Litigation

### *Assumption of Risk*

**Primary assumption of risk doctrine bars claim of "Burning Man" participant who fell into fire.**

*Beninati v Black Rock City, LLC* (2009) 175 CA4th 650, ___ CR3d ___

Plaintiff was a regular attendee of the annual Burning Man Festival, which features the burning of a 60-foot wooden structure of a man in front of a crowd of thousands. When the inflamed structure collapses, participants will often approach the fire and throw objects into it. Plaintiff was injured when he tripped and fell into the Burning Man fire, and he sued the festival promoter. Defendant filed a motion for summary judgment asserting primary assumption of risk, and prevailed.

The First District Court of Appeal affirmed. Plaintiff erroneously asserted that the primary assumption of risk doctrine applies only to rule-based or, at least, active sports. In *Knight v Jewitt* (1992) 3 C4th 296, 309, 11 CR2d 2, however, the supreme court held that primary assumption of the risk applies to activities involving an inherent risk of injury to voluntary participants, when the risk cannot be eliminated without fundamentally altering the nature of the activity. In this case, the risk of falling into the flames was inherent, obvious, and necessary to the event. Therefore, plaintiff assumed the risk.

### *Damages*

**Trial court must distinguish funds allocated to past medical expenses within settlement before ruling on Medicaid lien recovery.**

*Lima v Vouis* (2009) 174 CA4th 242, ___ CR3d ___

Minor plaintiff was born prematurely and has cerebral palsy. Because she qualified for Medicaid, the Department of Health Services (DHS) paid for her medical care. Through her guardian ad litem, plaintiff sued defendant for medical negligence, but eventually filed a petition for a compromise of her claim; she asserted that her total damages were $14 million, but that defendant had offered to settle for 6.75 percent of her damages, or $950,000. At the same time, plaintiff moved to extinguish all but 6.75 percent of the $319,275 lien DHS had placed, under Welf & I C §14124.74, on any recovery from defendant. The trial court approved the statement of plaintiff's total damages, including more than $435,000 in past medical costs, and the total settlement amount. However, it denied plaintiff's motion to extinguish the DHS lien. Plaintiff appealed.

The Second District Court of Appeal reversed and remanded. Under *Arkansas Dep't of Health & Human Serv. v Ahlborn* (2006) 547 US 268, 164 L Ed 2d 459, 126 S Ct 1752, a medical lien holder can only claim that portion of a settlement that represents medical expenses. Here, although the trial court distinguished which portion of plaintiff's total damages was allocated to past medical expenses, it did not distinguish which portion of the *settlement* was so allocated. Because DHS is only entitled to the share of plaintiff's settlement that represents past medical costs, it cannot recover the full amount of its lien from the settlement without impermissably recovering funds that are allocated to other damages. Although *Ahlborn* did not mandate the use of a particular formula for determining how to allocate medical and nonmedical damages in an unallocated settlement, the portion of the settlement that represents payment of past medical expenses must be distinguished using some rational approach. *Bolanos v Superior Court* (2008) 169 CA4th 744, 754, 87 CR3d 174. The trial court may use plaintiff's approach for allocation—reducing medical costs by using the settlement-to-actual-damages ratio—or any other method that is equitable and fair.

### *Limitation of Actions*

**Negligence claim was not equitably tolled when defendants were added to workers' compensation proceeding after statute of limitations had expired.**

*Aguilera v Heiman* (2009) 174 CA4th 590, 95 CR3d 18

Plaintiff was injured on a construction job at a condominium in November 1997. Within a year, he filed for workers' compensation benefits, naming his employer, Mark Hruby, and the Uninsured Employers Benefits Trust Fund as defendants. Heiman, the property manager, was joined to the proceeding in June 1999, and the condominium owners' association was added in August 1999. The proceeding resulted in a finding that Hruby was plaintiff's employer and liable for workers' compensation, but the WCAB determined that Heiman, not Hruby, was plaintiff's employer for workers' compensation purposes. Heiman petitioned for a writ of review, and the Second District Court of Appeal determined that Hruby and the association shared liability with Heiman. In April 2007, plaintiff filed a negligence suit against Heiman and the condominium owners' association, and they demurred on grounds including the statute of