Kaiser Permanente pays $556 million for medicare fraud while claiming there is no money for striking workers

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The ongoing strike by 31,000 nurses, technicians, and other healthcare workers at Kaiser Permanente in California and Hawaii has entered its second week, amidst an eruption of strikes and protests across the country. For three weeks, 15,000 nurses in New York City have been on strike; thousands of Kaiser pharmacists and technicians are set to join the pickets on the west coast in the coming days.

Kaiser Permanente pleads poverty when it comes to vital issues such as safe staffing ratios and pay increases to ensure staff retention. But it has quietly agreed to pay $556 million to settle allegations of Medicare fraud with the state of California, underscoring that "non-profit" healthcare operates no differently from any other corporation.

The settlement stems from Kaiser's systematic exploitation of the Medicare Advantage (MA) risk-adjustment system, a federally mandated program designed to compensate insurers for patients with more complex health needs. Under MA, the Centers for Medicare & Medicaid Services (CMS) pays private insurers a fixed monthly amount per enrollee, adjusted upward for documented illnesses. Such a system creates a strong financial incentive to maximize coding of diagnoses, turning patient records into revenue-generating instruments.

Federal prosecutors allege that between 2009 and 2018, Kaiser carried out a multi-state scheme to inflate risk scores through automated and coercive practices. The primary tool was the retroactive use of medical record "addenda." Typically intended to correct minor errors shortly after a visit, addenda were instead repurposed as a revenue tool.

Physicians were pressured to add diagnoses to patient charts months or even years after visits, often for conditions that were never evaluated or treated. Internal systems identified "missed" diagnoses through data mining of prior records or lab results, sending queries to clinicians that framed coding as a performance requirement.

Physicians and facilities were assigned risk-adjustment targets and tracked on internal dashboards, with financial incentives or penalties tied to coding output. Court filings estimate that roughly 500,000 unsupported diagnoses were added, generating approximately $1 billion in improper Medicare payments.

The $556 million settlement, while large by most measures, represents only a fraction of the alleged overbilling and a minor cost for an institution with billions in reserves.

The practices exposed at Kaiser are widespread throughout the healthcare industry. UnitedHealth Group (UHG) has faced multiple similar allegations, using its vertically integrated structure and vast data systems to identify diagnoses that increase Medicare payments. Meanwhile they are accused of ignoring evidence that existing diagnoses were unsupported or incorrect and therefore required repayment of previously overbilled funds. In both cases, corporate control over clinical data was used to maximize revenue.

Companies defend these practices as "thorough documentation," exploiting the complexity of the Hierarchical Condition Category coding system. Vertical integration, particularly UHG's control over physician networks through Optum, has enabled insurers to exert unprecedented influence over diagnosis capture and clinical decision-making. Programs such as HouseCalls, marketed as care for underserved populations, were used primarily to identify high-value diagnoses, many of which were never treated, turning illness itself into a source of

profit rather than a basis for care.

The fact that UHG's legal defense was largely successful, the government is unwilling to hold major healthcare corporations accountable. A precedent has been established in which formal "transparency" functions as a legal defense for exploitative behavior.

Kaiser's "non-profit" status is a sham. In 2024, it reported $115.8 billion in operating revenue, $12.9 billion in "net income," and nearly $67.4 billion in financial reserves, while executive compensation approached $93 million. Against this backdrop, a $556 million settlement amounts to a routine operating expense.

Beyond financial misconduct, the most damaging consequence of risk-adjustment fraud is the corruption of patient medical records. Inaccurate coding creates permanent records of fictitious or exaggerated illnesses, distorting care and exposing patients to unnecessary treatment or stigma. Investigations show millions of Medicare Advantage enrollees carry serious diagnoses without follow-up care, underscoring how illness has been transformed into a revenue stream.

UNAC/UHCP, the union covering striking workers, has issued statements portraying Kaiser's actions as a moral lapse or a failure of management ethics. Its January 2026 report named "Profit Over Patients" frames the issue as "mission drift," rather than the predictable outcome of subordinating healthcare to market imperatives.

This from Kaiser's partners of nearly 30 years in their Labor Management Partnership. In return for involvement in this scheme funded with millions of dollars from Kaiser, the union is responsible for limiting and suppressing organized resistance from workers. Its insists that fraud and mismanagement are isolated abuses fixable through oversight, governance or clinician "voice," rather than requiring a determined struggle from below against the entire for-profit healthcare model, which is incompatible with public health.

Privatization of Medicare has been a bipartisan project carried out over decades. The Reagan administration introduced prospective payment systems that encouraged competition and for-profit hospital operations. Under Clinton, Medicare+Choice (later Medicare Advantage) allowed private insurers to profit directly from public funds. Bush expanded the program further, diverting billions from public resources into private hands.

Subsequent administrations, from Obama's Affordable Care Act to the Trump-era Direct Contracting and Primary Care First models, deepened the focus on cost control and profit, often at the expense of patient needs. Value-based payment models reward savings over care, incentivizing providers to see more patients in less time, restrict treatments, and shift care to cheaper alternatives.

Kaiser is often portrayed as a model non-profit healthcare system, guided by community well-being rather than revenue. The $556 million Medicare fraud settlement exposes this image. For an institution of Kaiser's size, wealth, and financial sophistication, such penalties function less as deterrents than as routine operating costs. In this context, misconduct is not an aberration but a systemic feature.

The ongoing strike by 31,000 by nurses, laboratory technicians, and other staff is against understaffing, burnout and unsafe conditions driven by relentless cost cutting. That this takes place even as management extracts revenue through inflated risk scores and financial maneuvers shows this struggle is inseparable from a broader question of whose social interests dominate healthcare, whether medicine is organized to meet human needs or to generate profit.

What is required is independent, class-based organization that links workplace struggles to opposition to Medicare privatization and the commodification of medicine.

The Kaiser settlement illustrates the real costs imposed when healthcare is subordinated to capital. While executives and regulators treat fraud penalties as minor expenses, frontline workers and patients bear the consequences daily.

Among nurses, a different mood is taking hold. Many have spoken out in support of a general strike against the Trump administration, noting that Alex Pretti, the man murdered by ICE agents in Minneapolis, was also a nurse. The strikes in California, Hawaii and New York reflect a growing recognition that the fight for ethical medical practice and safe staffing is inseparable from the struggle against profit-driven healthcare.