Kaiser Permanente files $95 million insurance lawsuit after record Medicare Advantage fraud settlement

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The month-long strike of 31,000 healthcare workers at Kaiser Permanente was abruptly brought to an end by the United Nurses Associations of California/Union of Health Care Professionals (UNAC/UHCP) as a series of legal confrontations arose, which expose the rottenness of America's profit-driven healthcare system.

On February 20, Kaiser Foundation Health Plan and Kaiser Foundation Hospitals filed suit against nine major insurers, led by American International Group and Chubb Limited, seeking up to $95 million in directors and officers liability coverage. The payment would partially offset Kaiser's recent $556 million settlement of whistleblower allegations accusing the organization of manipulating Medicare Advantage reimbursements through systematic diagnostic "upcoding."

Kaiser employees will now confront the consequences of the betrayal of the UNAC/UHCP bureaucracy—deteriorating wages, medical coverage and working conditions. By contrast, the healthcare giant is maneuvering for reimbursement after a record fraud payout.

In January 2026, Kaiser affiliates agreed to pay $556 million to resolve False Claims Act allegations brought by the US Department of Justice. The resolution, the largest recovery ever tied to Medicare Advantage risk-adjustment practices, involved multiple entities, including Kaiser Foundation Health Plan Inc. and several Permanente Medical Groups.

The case originated in whistleblower lawsuits filed by former employees Ronda Osinek and James Taylor. Osinek, a medical coder, alleged that Kaiser pressured physicians to retroactively add diagnosis codes in order to increase reimbursement rates. Taylor, a physician medical director, reportedly attempted to correct coding irregularities internally before filing his own complaint. Under the False Claims Act's whistleblower provisions, the former Kaiser employees—the relators in the case, ie., the ones who brought the case on behalf of the US government—received a combined $95 million.

Prosecutors contended that between 2009 and 2018 Kaiser conducted retrospective record reviews that generated roughly 500,000 unsupported diagnoses. These additions allegedly produced about $1 billion in excess Medicare payments, despite internal compliance warnings.

Kaiser denied wrongdoing, characterizing the dispute as a technical disagreement over evolving federal guidance. Management settled to avoid protracted litigation and did not have to admit liability.

The negotiated outcome fell well below the government's initial estimate of $1 billion in improper payments. Notably, the agreement did not impose a Corporate Integrity Agreement, suggesting the government's reluctance to escalate oversight of one of the nation's most powerful healthcare systems.

Barely weeks after finalizing the settlement, Kaiser initiated a second legal offensive, this time against its own insurers. The organization argues that its $556 million payment constitutes a covered "loss" under directors and officers liability policies issued by insurers led by National Union Fire Insurance Company.

Kaiser's legal argument rests on three central claims. First, it characterizes the payment as a standard settlement falling squarely within policy language covering damages and negotiated resolutions. Second, because the settlement involved no admission of liability, Kaiser maintains insurers cannot retroactively classify the conduct as fraudulent to invoke exclusions. Third, Kaiser contends False Claims Act settlements are compensatory (intended to reimburse the government) rather than disgorgement of profits, which is generally uninsurable.

The settlement represents a routine business risk: a legal payment made to manage exposure and ensure organizational stability. Kaiser further asserts it reasonably expected coverage, noting that its policies contained no explicit exclusions for Medicare Advantage coding disputes

and accusing insurers of invoking broad public-policy defenses absent from contractual language.

The insurers countered with the so-called "uninsurability defense." They argue the settlement represents restitution of funds Kaiser allegedly obtained improperly and therefore does not constitute a true loss. Returning money to the government, insurers claim, merely restores funds Kaiser was never entitled to keep. Allowing coverage, they warn, would create moral hazard by enabling corporations to treat regulatory violations as insurable costs of doing business.

The dispute reveals what is described as "circular restitution." Federal investigators alleged Kaiser received roughly $1 billion in excess payments. By settling for $556 million, the organization already retained about $444 million of the contested amount. If Kaiser successfully recovers $95 million from insurers, its effective settlement cost would fall to approximately $461 million, leaving an estimated net retention of more than $500 million, allegedly through fraud.

For a system generating over $115 billion in annual revenue, the settlement functions less as punishment than as a manageable expense. The circular flow of funds spreads costs across taxpayers, patients and insurance markets.

The legal conflict between Kaiser and its insurers exposes the character of contemporary corporate operations, in which enormous entities navigate regulatory frameworks through settlements, litigation and financial engineering over basic social needs like healthcare.

Kaiser's pursuit of insurance coverage for a record fraud settlement encapsulates the absurdity of a healthcare system dominated by finance and evokes methods associated with the broader Wall Street oligarchy.

Corporate wrongdoing is treated as negotiable risk while financial institutions and ultimately workers are pressured to absorb costs. The result resembles a system of legalized racketeering in which public funds are extracted, partially returned and then redistributed through legal mechanisms.

The UNAC/UHCP apparatus shut down the powerful month-long strike without a new contract or tentative agreement, let alone a vote by its members. This underscores the compounded threats healthcare workers face from corporate wealth, profit-driven healthcare and management's "labor partners." While executives debate insurance coverage for a half-billion-dollar settlement, frontline workers continue to confront workloads that threaten both patient safety and their own livelihoods.

While the union bureaucracy tries to limit the outlook of workers to trade union negotiations, the Kaiser litigation demonstrates that healthcare crises are inseparable from the financial architecture governing the capitalist system. Billing practices, insurance markets and corporate reserves shape not only profits but staffing levels, patient outcomes and workplace conditions.

Regardless of the verdict, the litigation has exposed the fraudulent "nonprofit" status of Kaiser Permanente and Medicare Advantage. No outcome under the current framework addresses the underlying reality: healthcare under capitalism operates through complex financial circuits that prioritize revenue extraction over public health. Fraud settlements, insurance disputes and regulatory negotiations represent symptoms of a system structured around profit rather than care.

Kaiser, insurers, corporations, the state and political representatives of both big business parties ultimately converge on one premise: the costs of legal and financial schemes must be borne by workers, who finance Medicare through taxes on their salaries, pay insurance premiums and deliver the labor sustaining healthcare institutions. In return, they confront understaffed facilities, rising costs and declining working conditions.

The Kaiser struggle raises political questions extending beyond wages and staffing. It poses the issue of who controls healthcare and for whose benefit it operates. The labor bureaucracy's termination of the strike underscores the need for workers to break free from the stranglehold of the union apparatus through the building of rank-and-file committees, controlled democratically by workers in the hospital and clinics.

This is a critical step in the development of a political movement of the working class against capitalist, for-profit medicine and the two corporate-controlled parties that defend it, and to replace it with a socialist system, which guarantees free, high quality healthcare to all.