2026

PROFITS OVER PATIENTS:

Kaiser Permanente's Shift in Institutional Priorities and the Dire Consequences to Health Care

Contents

Preface: Purpose and Methodology

This report is released by United Nurses Associations of California/United Health Care Professionals (UNAC/UHCP), a union representing a total of 42,000 registered nurses and other health care professionals. UNAC/UHCP is affiliated with NUHHCE, AFSCME, AFL-CIO, and is a member of the Alliance of Health Care Unions, a group of unions representing 60,000 Kaiser Permanente employees. This report is issued solely by UNAC/UHCP.

Why UNAC/UHCP is issuing this report

UNAC/UHCP is releasing this report due to Kaiser Permanente's escalating emphasis on profit, expansion, and asset accumulation. Kaiser has lost sight of the mission and values that once defined it—principles that put people, not profits, at the center. Today, Kaiser Permanente appears increasingly driven to expand market reach, out-competing rivals, and maximizing financial returns, including investments that are inconsistent with the organization's nonprofit purpose and stated commitments to community health.

This shift is not abstract. It is felt in the daily reality of our members and our patients: persistent understaffing, intensifying workloads, burnout, delayed care, and instability across critical roles that support safe patient care.

Our members are frontline caregivers who understand better than any high-level manager or executive what it takes to deliver high-quality care. We see first-hand how far Kaiser Permanente has strayed from the mission it publicly promotes. And we see the daily consequences of that.

This report is also issued in the context of ongoing collective bargaining for a new agreement covering approximately 31,000 UNAC/UHCP-represented professionals across California and Hawaii. Bargaining involves UNAC/UHCP members and Kaiser negotiating over working conditions such as staffing, scheduling, training, and safety in an effort to improve the quality and sustainability of patient care. This only happens if Kaiser is willing to make the necessary investment. When Kaiser claims it cannot afford meaningful improvements and summarily rejects proposals that would enhance patient care and health care provider well-being, its financial priorities merit detailed scrutiny.

The goal of creating this report is to inform Kaiser health plan members, patients, policymakers, and the broader community about the values and resource-allocation choices that shape Kaiser's approach to bargaining with UNAC/UHCP and the impact of those decisions on care delivery and the workforce.

Preface: Purpose and Methodology

We aim to spark an urgently needed public conversation about how Kaiser's priorities appear to undermine patient care and impede our members' ability to achieve a fair contract—one that includes the protections necessary for caregivers to consistently deliver high-quality care.

Kaiser Permanente's public posture often emphasizes its mission, community benefit, and nonprofit values. Yet if Kaiser is simultaneously accumulating vast financial reserves, generating substantial "net revenue" (functionally profit), and allocating significant resources toward financial strategies and investments that do not strengthen patient care, this raises an obvious and unavoidable question for bargaining purposes and for the public: What are Kaiser's priorities? Do they align with its mission and with the needs of the workforce and patients?

This is also why the role of watchdogs is so critical in health care systems, including Kaiser Permanente. Transparency and accountability do not happen on their own; they depend on people inside the system who are willing to speak up. Caregivers often rely on the ability to raise patient-care concerns through their union—both in collective bargaining and other channels.

Sometimes, a whistleblower acts under the False Claims Act, as in Medicare fraud cases brought forward by Kaiser employees. And sometimes unions engage in principled public advocacy, seeking regulatory action on behalf of patients. For example, the National Union of Healthcare Workers (NUHW) has been a strong, persistent advocate regarding Kaiser's mental health wait times, pushing for regulatory intervention and enforcement when delays and access barriers became systemic and harmful to patients.

Whether through union advocacy, whistleblower actions, or engagement with regulators and legislators, these voices serve the same function: they shine a light on practices that would otherwise remain hidden, ensuring that powerful institutions are held accountable when internal priorities endanger care quality and medical integrity. Attempts by any employer, including Kaiser Permanente, to retaliate against whistleblowers or unions for speaking out do more than violate the law—they weaken critical safeguards that protect patients and the public.

Preface: Purpose and Methodology

That is why UNAC/UHCP will continue to defend the right—and the responsibility—of health care workers to speak up on behalf of their patients, whether individually or collectively through their union, when institutional practices drift away from stated missions and public trust.

Methodology and Sources

This report draws on publicly available and third-party sources, including IRS Form 990 and Form 5500 filings, SEC filings, financial statements, government regulatory and enforcement actions, court records, and established investigative journalism. Publicly disclosed information regarding Kaiser Permanente's investments, partnerships, and governance structure was analyzed to identify potential conflicts of interest and possible misalignment with Kaiser's stated nonprofit mission.

To ensure accuracy and analytical rigor, key findings were validated through cross-checking multiple independent sources whenever possible (for example, comparing financial disclosures against regulatory actions, court filings, and reputable reporting on the same entities or transactions). Where sources use different terminology or accounting conventions, the report makes note of those distinctions and relies on the most authoritative primary documentation available.

In addition, firsthand accounts from Kaiser Permanente patients and health care workers were collected through a publicly accessible digital portal between October and December 2025. These accounts are presented as lived experiences in the workplace, illustrating how institutional priorities can translate into real-world consequences. Firsthand accounts are not always treated as a substitute for documentary evidence. However, they provide critical context and help identify recurring patterns that can be evaluated against the public record.

A note on terminology: "profits" and Kaiser Permanente's structure

Kaiser Permanente comprises both nonprofit and for-profit entities. The nonprofit entities include Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, and certain related organizations. The for-profit entities include the various Permanente Medical Groups and other affiliated organizations. Together, these entities employ approximately 31,000 UNAC/UHCP members, all operating under the Kaiser Permanente brand.

Preface: Purpose and Methodology

Throughout this report, the term “profits is used in an inclusive manner, even when discussing nonprofit organizations. Nonprofits do not technically earn “profits” in the legal sense; instead, their financial performance is measured using terms such as “net revenue,” “surplus,” “revenue over expenses,” or “change in net assets.” References to “profits” in connection with Kaiser Permanente’s nonprofit entities, means whichever of these metrics the particular entity uses to describe what is commonly understood as profit. This distinction matters because nonprofit organizations can—and do—accumulate substantial wealth, and those resources should be directed exclusively toward advancing the organization’s charitable mission. This report documents evidence suggesting that many Kaiser Permanente entities have acted in ways that are inconsistent with that purpose.

As used in this report, the term “Kaiser Permanente refers to one or more of the following: the nonprofit Kaiser Foundation Hospitals; the nonprofit Kaiser Foundation Health Plan; entities related to one or both; one or more of the primarily for-profit groups under the umbrella of Permanente Medical Groups (and related entities); and one or more Kaiser investment funds, including but not limited to certain employee benefit pension plans whose investments are decided solely by Kaiser executives and Kaiser-selected advisors or vendors.

This report does not refer to investments by employee benefit plans that share control with union-appointed trustees. The pension fund investments included when we say “Kaiser” are solely those in plans whose investments are ultimately controlled by one or more Kaiser employers.

What readers should expect

The sections that follow examine whether Kaiser Permanente’s financial behavior, investment choices, and governance practices align with the mission it claims—and what those choices mean for patient care and the workforce. UNAC/UHCP offers this report to promote accountability and to strengthen the case for working conditions that reflects the realities and experiences of patient and frontline caregivers. UNAC/UHCP members are not asking for extravagance; they are advocating for safe staffing, sustainable careers, and a health care system that puts patients first. If Kaiser Permanente has the resources to expand its reserves and pursue controversial investments, then it has the resources—and responsibility—to invest in the people who deliver care and in the patients who depend on it.

EXECUTIVE SUMMARY

Kaiser Permanente has lost sight of its mission and the values that once defined it. It has abandoned its roots and turned away from the founding principles that once put people–not profits–at the center. It now appears to be solely focused on expanding its empire, dividing and conquering the competition, and growing its bottom line to make as much profit as possible.

Kaiser Permanente is running its health care system like a trading desk. In 2024,[1] it generated $12.9 billion in profits.

Kaiser claims it "can't afford" to invest in staffing, retention, and patient safety—but the numbers continue to tell a different story. Kaiser reported approximately $7.9 billion in net income across the first three quarters of 2025 alone—before even counting Q4.[2,3,4]

Instead of reinvesting in patient care or stabilizing its workforce, Kaiser invests in foreign entities with hedge funds, private equity groups, and Russian nationals. This includes companies like CoreCivic and the GEO Group, which run ICE detention centers and provide health care and living conditions so substandard they border on criminal.

To grasp the extent to which Kaiser is willing to go to secure power and accumulate wealth, one needs only examine its alleged conduct, a documented pattern that includes willful fraud and regulatory evasion.

Kaiser Permanente's alleged attempts to boost profits by enacting a systematic scheme to overcharge the Medicare program has led to multiple lawsuits filed against it by the United States Department of Justice and others.

Underserved patients facing unjustified barriers to access and dangerously long wait times—sometimes months for an appointment—have also been left with little choice but to file lawsuit after lawsuit just to be heard above the relentless grind of Kaiser's profit machine.

Kaiser's corporate leaders are surrounded by advisers far removed from the front lines—out of touch with both their workforce, the realities of their operations, and the communities they're entrusted to protect. Moreover, Kaiser pays its executive leadership and board members salaries that would make actual mission driven nonprofits blush.

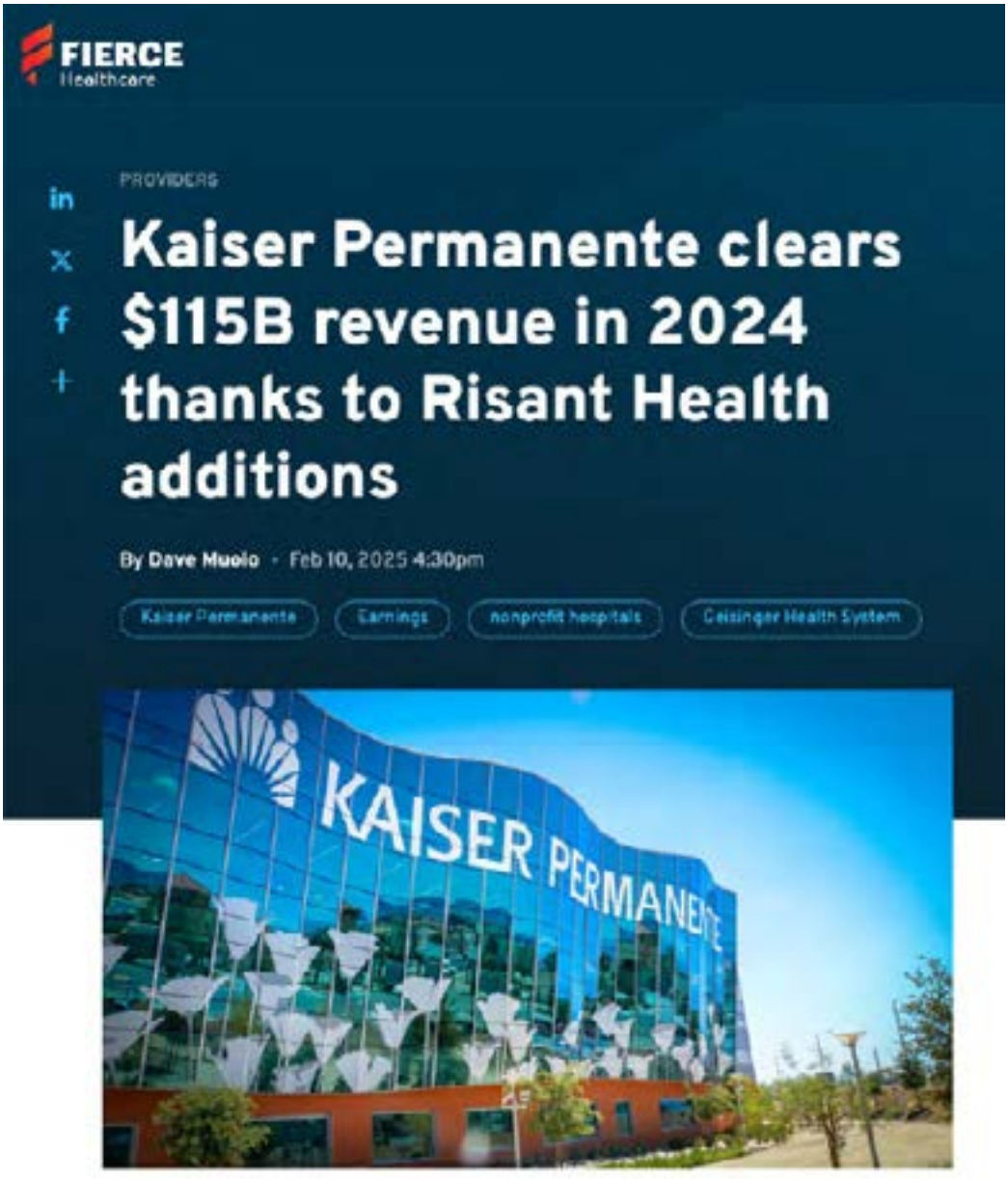
All of this leads up to 13.1 million[5] Kaiser health plan members across the country receiving the short end of the health care stick. Until Kaiser is held accountable, its relentless pursuit of profit and expansion will continue to erode the very care and trust that has historically served as its bedrock foundation since 1945.

I. INTRODUCTION

Henry J. Kaiser built massive shipyards and industrial operations during World War II. He believed that the men and women who devoted their lives to work for him deserved to have those same lives cared for—so he created a health system. It was one of the earliest models of prepaid, labor-management health care the country had ever seen. It was a system rooted in partnership, shared purpose, and the idea that healthy workers meant happier communities. He recognized that real health equity meant ensuring everyone receives the same high-quality care, regardless of race, gender, or background. Even during segregation, Henry Kaiser rejected discriminatory practices[6]—refusing to separate Black and white patients[7] in Kaiser hospitals and waiting rooms. Sadly, Kaiser Permanente has betrayed those principles of partnership and equity, elevating corporate greed over the care of the very communities it was built to serve—a reversal that would have been unthinkable to its founder.

Kaiser Permanente—the etymology of which translates from Latin and German origins, meaning "Permanent Emperor"—now fits all too well, in a betrayal of its true origin. Those origins lie with founder Henry J. Kaiser, who set out to build something democratic and noble. The organization treats staff and patients like subjects in a corporate kingdom. Overworked and underpaid health care workers are forced to treat underserved and overcharged patients. The result is burnout, high turnover rates, and sick health care plan members slipping through the cracks in Kaiser Permanente's sprawling empire.

Kaiser Permanente claims to uphold its founder's legacy through its longstanding Labor-Management Partnership[8], but that commitment has become hollow. What was once a high-water mark in ethical labor relations now groans under chronic understaffing[9], relentless cost-cutting[10], and decisions made far from the front lines. These practices don't just violate the spirit of Kaiser's stated nonprofit mission—"to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve"[11]—they risk materially compromising patient care, exposing patients and communities to avoidable risk.



Source: Fierce Healthcare

II. REVENUE, PROFITABILITY, AND USE OF SURPLUS FUNDS

Kaiser Permanente holds approximately $66 billion in unrestricted reserves, making it one of the most heavily-financed nonprofit health care organizations in the United States.[12]

In recent years, Kaiser has continued to maintain and grow large financial surpluses. Rather than drawing down these reserves to address persistent operational challenges, it has expanded aggressively, investing its resources in new markets. This includes its acquisition of Hometown Health, Renown Health's health insurance division in Northern Nevada.[13] In 2023, Kaiser announced through its newly formed subsidiary, Risant Health, that it had acquired the 10-hospital Geisinger system in Pennsylvania, followed by Risant's acquisition of Cone Health in North Carolina in 2024.[14]

Kaiser's unusual financial capacity is further demonstrated by its ability to conduct extraordinarily large asset sales, including about $5 billion in private fund investments sold in 2023 to major Wall Street firms Ardian, Blackstone Inc., and Apollo Global Management Inc.[15] In 2024, Kaiser Permanente sold an additional $3.5 billion in assets.[16] Such large deals of this type are usually associated with institutional investors, involving the world's largest retirement systems and government-backed funds, not nonprofit health care systems.

As reported in the Wall Street Journal, the "[h]ealth care giant Kaiser Permanente became one of the world's largest private-markets investors by 2022." The article further highlights that "[t]he health care giant's sales of private-equity fund stakes follow years of piling on and driving its holdings to almost $57 billion."[17]

Concerns about large reserves are not new. In 2008, the Colorado Division of Insurance, after determining that its surplus had grown too large, reached a $155 million settlement with Kaiser Permanente.[18] Marcy Morrison, Colorado insurance commissioner at the time, explained, "Some of the nonprofits are growing, more than substantially. We need to know what these nonprofits are doing."[19] Former Colorado House Speaker Morgan Carroll also observed, "[a]n excessive and continually growing surplus is a good indicator that insurance rates will actually be decreased." [20]

> "[a]n excessive and continually growing surplus is a good indicator that insurance rates should actually be decreased."
>
> — Former Colorado House Speaker Morgan Carroll

II. REVENUE, PROFITABILITY, AND USE OF SURPLUS FUNDS

KAISER PERMANENTE REVENUE

	2020	2021	2022	2023
Revenue	$66,679,377,605	$68,095,348,490	$70,804,102,457	$75,101,306,911
Net Income	$2,173,621,294	$924,641,513	-$645,688,717	$745,302,910
Net Assets	$2,415,768,478	$5,853,207,789	$9,662,338,354	$9,322,119,869

Source: Based on publicly available IRS Form 990 filings for Kaiser Foundation Health Plan from 2020 to 2023.

Source: Analysis of financial reports of Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals and each of their Subsidiaries and Affiliates from 2020 to 2023. 2024 data from https://capitalandmain.com/five-day-strike-by-kaiser-permanente-workers-is-about-more-than-money

II. REVENUE, PROFITABILITY, AND USE OF SURPLUS FUNDS

Denver Post journalist Michael Booth noted that insurers' "enormous cash surpluses" were prompting calls for greater community investment or rebates to employers or plan members, underscoring that tax-exempt status carries public obligations.[21]

Kaiser Permanente has developed an unusually strong financial profile for a tax-exempt nonprofit health care system, marked by sustained revenue growth, massive cash reserves, and a rapidly expanding investment operation. What began as proportionate investments years ago pivoted in 2015 into a full-scale investment powerhouse generating multi-billion-dollar returns more in line with Wall Street than a mission-driven nonprofit.

Based on publicly available IRS Form 990 filings,[22] Kaiser Foundation Health Plan (KFHP) reported $3.19 billion in net income between 2020 and 2023. Despite an unprecedented global pandemic, acute workforce shortages, and escalating patient needs, KFHP continued to generate multi-billion margins.[23]

In 2024, Kaiser Permanente reported[24] $12.9 billion in net income across its consolidated entities, including Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, Risant Health, Inc., and their affiliates.[25] *Note: Form 990 data for 2024 is not yet publicly available.*

Concerns about accumulation of large surpluses are longstanding. Regulators in California revoked Blue Shield of California's tax-exempt status over similar concerns, including $4 billion in reserves.[26] This is just a small fraction of Kaiser's $66 billion. In several other states, regulators have denied or reduced proposed rate increases and called for enhanced community investment when nonprofit insurers accumulated excessive surpluses. Such actions raise questions about the accumulation of significant cash reserves.

In several other states, the accumulation of large reserves has led regulators to deny or reduce proposed rate increases and to call for enhanced community investments, reinforcing that nonprofit tax benefits carry obligations to serve the public, and ensuring that significantly high levels of financial reserves remain aligned with nonprofit expectations and public benefit.

Examples include:

- Oregon regulators cited "growing financial reserves" when they reduced Regence BlueCross BlueShield's requested 22% premium increase to 12.8%.[27]

II. REVENUE, PROFITABILITY, AND USE OF SURPLUS FUNDS

- In Michigan, Administrative Judge David Lick rejected a proposed rate hike and pointed to Blue Cross Blue Shield of Michigan's $2.4 billion reserves as "very high."[28]
- Regulators considered requiring CareFirst's D.C. subsidiary (a nonprofit) to spend down excess surplus for community health needs, under a District of Columbia law requiring "community health reinvestment."[29]

There is a clear disconnect: as Kaiser Permanente's financial assets, investment activity, and institutional reach expand and frontline workers continue to report chronic understaffing, its financial priorities may no longer be consistent with legal and ethical obligations to patient care.

Despite this massive accumulation of wealth, Kaiser has not reduced premiums or held them steady. To the contrary, plan premiums increased by an average of 8.2% in Northern California and 5.1% in Southern California for 2025,[30] followed by newly announced average increases of 7.1% in Northern California and 6.5% in Southern California for 2026.[31]

As health plan premiums continue to rise and Kaiser continues to hoard massive reserves, frontline workers report chronic understaffing, unacceptable patient wait times, and deteriorating conditions inside Kaiser facilities—conditions that raise serious concerns about patient safety and access to care.

Community groups and labor coalitions argue that Kaiser has accumulated excessive reserves while failing to reinvest sufficiently in staffing and service delivery, undermining its nonprofit mission and community obligations.[32]

Based on publicly available financial data[33] and credit-rating analyses, Kaiser's unrestricted reserves are reasonably projected to continue growing, not shrinking. With reserves of roughly $66 billion at the end of 2024, a conservative estimate places reserves at approximately $68–72 billion by the end of 2025, and $70–75 billion by the end of 2026, assuming continued positive operating results and investment income consistent with recent years.

These projections underscore that Kaiser is operating from a position of extraordinary financial strength. As a result, lawmakers are increasingly questioning whether Kaiser Permanente's reserve accumulation, spending priorities, and premium increases align with public expectations or whether this predominantly nonprofit system has become a powerful health care enterprise leveraging tax advantages and financial scale to fuel corporate growth at the expense of patient care.

III. LEADERSHIP OVERVIEW

"We can't separate how we lead from who we are."

—Gregory A. Adams, Kaiser Permanente CEO and Chairman of the Board [34]

Kaiser's key decision-makers form a power structure far removed from the people the organization is supposed to serve. Its board is dominated by finance, corporate, and legal executives, while the physician-owned Permanente Medical Groups operate as profit-generating professional corporations with their own separate financial incentives. Kaiser Permanente Ventures adds yet another layer of commercial ambition, functioning as a venture-capital arm focused on high-growth investment opportunities.[35] These core leaders are further influenced by hedge-fund and private equity partners and outside financial advisors who shape the organization's investment strategies.

This current leadership structure in no way answers to frontline caregivers, to patients, to the communities Kaiser serves, and certainly not to the U.S. taxpayers who are unwittingly subsidizing its nonprofit status. Instead, authority flows through a corporate governance arm relentlessly oriented toward asset preservation, investment growth, and portfolio diversification.

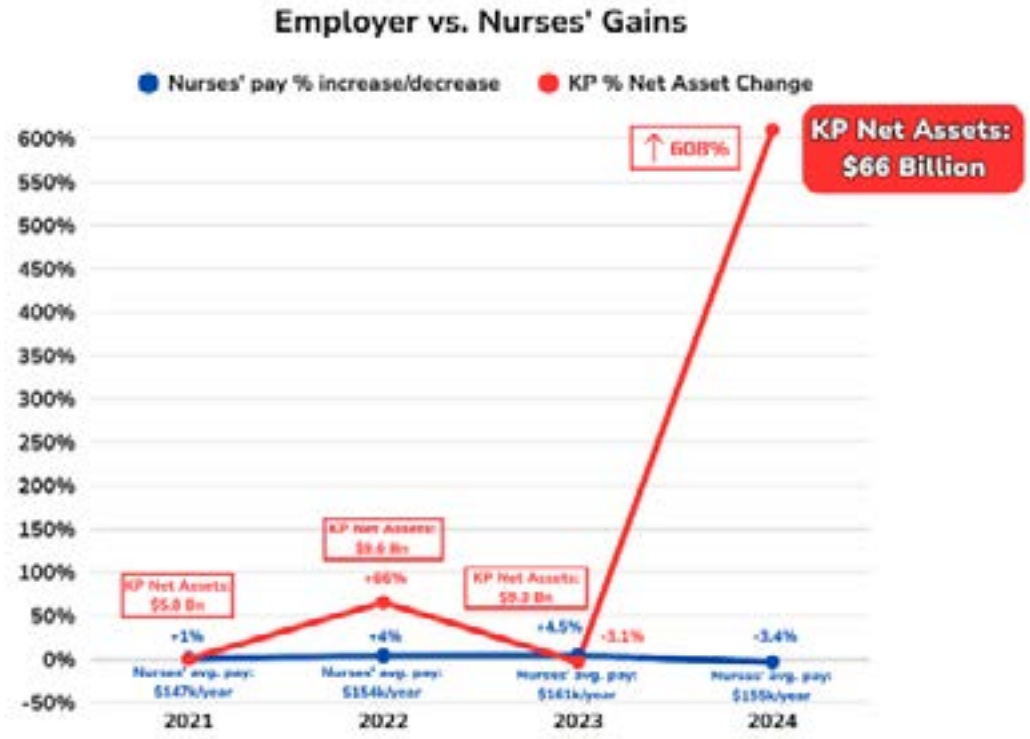
Between 2020 and 2022, Kaiser Permanente CEO and Chairman of the Board Gregory A. Adams' compensation rose 8.29% one year, then another 4.21% the next.[36]

Meanwhile, the wages of the workforce that keeps the system running, do not keep up with inflation and fall far below the soaring cost of living in the communities Kaiser serves. Kaiser Permanente's gain in net assets paints a jarring picture of double-digit percentage gains year-over-year—all while caregivers face losses in purchasing power—a gap that underscores Kaiser's deeply misplaced priorities. As Kaiser's reserves have skyrocketed by approximately 1,038% since 2021, many workers' wages have failed to keep up with inflation.

For example, the salary increases provided to UNAC/UHCP nurses over the past four years, when measured against inflation rates (calculations based on inflation rates according to the Consumer Price Index 2021: 4.7%; 2022: 8%; 2023: 4.1%; 2024: 2.9%).[37], has produced an erosion in their real purchasing power (as seen in chart on next page):

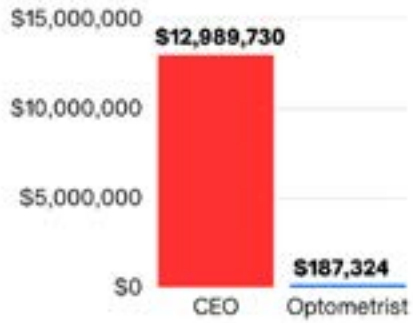
- 2021: -1.7%
- 2022: -5%
- 2023: -2.1%
- 2024: -.9% [38]

Source: Nurse loss based on nurse annual yearly wage (2080 hours), per analysis based on publicly available Collective Bargaining Agreements (CBAs) between KP and its various workers. Purchasing power loss calculations based on inflation rates according to the Consumer Price Index 2021: 4.7; 2022: 8; 2023: 4.1; 2024: 2.9



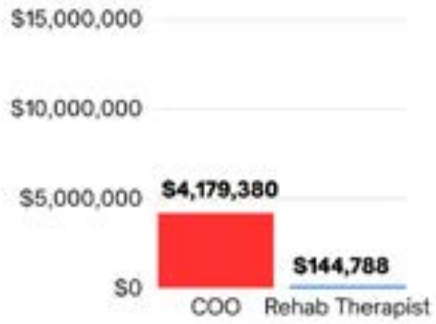
Source: Analysis of Kaiser's IRS Form 990 filings from 2021 to 2023; https://www.exposedbycmd.org/2025/10/18/as-kaiser-workersstrike-not-for-profit-is-sitting-on-67-billion/

AVERAGE PAY FOR KAISER PERMANENTE
CEO VS OPTOMETRISTS
(2020 - 2023)



AVERAGE PAY FOR KAISER PERMANENTE
CFO VS NURSES
(2020 - 2023)

AVERAGE PAY FOR KAISER PERMANENTE
COO VS REHAB THERAPISTS
(2020 - 2023)



Source: Analysis of Kaiser Foundation Health Plan Inc's IRS Form 990 filings from 2020 to 2023. Optometrists, nurses and rehab therapists pay analysis based on publicly available Collective Bargaining Agreements (CBAs) between Kaiser Permanente and its various workers.

III. LEADERSHIP OVERVIEW

Board of Directors

Kaiser board members earned an average annual salary of $251,000 based on publicly available IRS Form 990 filings in 2023.[39] At many major nonprofit hospitals, including Cedars Sinai Medical Center[40] and Children's Hospital Los Angeles,[41] board members typically serve on a voluntary basis with no annual salaries. This is standard practice across the nonprofit hospital sector, where board service is considered a form of community stewardship rather than a compensated role. In cases where nonprofit health care systems do compensate board members, those payments are usually more modest. For example, CommonSpirit Health, which, like Kaiser, is in the top three[42] largest California health systems, compensates its board members an average of $159,000 per year, based on publicly available IRS Form 990 filings in 2023.[43] In 2023, Kaiser Permanente paid its board members nearly 60% more than CommonSpirit Health.[44]

Kaiser's board mirrors that of a non-health care corporate enterprise with deep ties to finance and industry. Despite minor changes in 2025, the overall profile and governance orientation remain largely unchanged. Based on publicly available IRS Forms for the fiscal year ending Dec. 2023,[45] Kaiser had 15 Board members with the following professional experience:

33% with banking and investment backgrounds:

- **Jeff Epstein**, former EVP and CFO of Oracle, former investment banker at First Boston Corporation—Director Compensation: $265,915

- **Leslie S. Heisz**, extensive experience in investment banking and finance, serving in executive-level roles at firms including Lazard Freres & Co., Wasserstein Perella & Co. and Salomon Brothers—Director Compensation: $268,956

- **Judith A. Johansen**, JD, former president and CEO of PacifiCorp in Oregon, serves on the board[46] of IDACORP, Inc., which Kaiser Permanente Group Trust invests and/or has invested in[47]—Director Compensation: $266,500

- **Margaret E. Porfido,** JD, advisor to private equity group - PSP Investments,[48] Canada's largest pension investment manager—Director Compensation: $291,083

- **Edward Y W Pei,** Executive Vice President at Hawaii Bankers Association, previously Executive Vice President-Consumer Banking Group at First Hawaiian Bank which Kaiser Permanente Group Trust invests and/or has invested in[49] (First Hawaiian Bank is a member bank of Hawaii Bankers Association, which Edward is EVP)—Director Compensation: $53,623

III. LEADERSHIP OVERVIEW

Board of Directors (cont'd)

- **David F. Hoffmeister,** former SVP and CFO of Life Technologies Corporation and serves[50] on the boards of directors of Celanese Corporation (since 2006), Glaukos Corporation (since 2014) and ICU Medical, Inc. (since January 2018), which Kaiser Permanente Group Trust invests and/or has invested in[51]—Director Compensation: $280,951

- **Jenny J. Ming,** former president and CEO of Charlotte Russe, serves[52] on the board of Levi Strauss & Co., which Kaiser Permanente Group Trust invests and/or has invested in[53]—Director Compensation: $248,772

47% from IT, law, transportation, retail, entertainment, and food industries:

- **Ramon Baez,** former SVP of Hewlett-Packard Enterprise and former Vice President of information technology services and Chief Information Officer of Kimberly-Clark Corp—Director Compensation: $252,951

- **David J. Barger,** former CEO/Co-Founder of JetBlue Airways—Director Compensation: $234,000

- **Matthew Ryan,** CEO of Soli Organic Inc.—Director Compensation: $250,951

- **Vivek Sharma,** CEO of InStride—Director Compensation: $261,456

- **Kim J. Kaiser,** retired senior pilot, Alaska Airlines—Director Compensation: $0

20% from health care leadership:

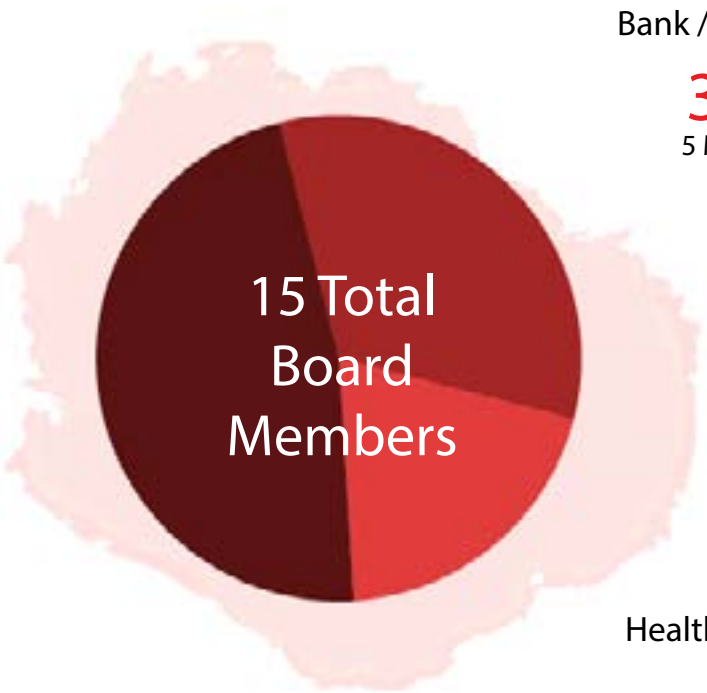
- **Regina Benjamin,** MD, MBA, founder and CEO of BayouClinic/Gulf States Health Policy Center—Director Compensation: $219,620

- **Richard P. Shannon,** MD, Senior Vice President and Chief Medical Officer for Duke University Health System—Director Compensation: $236,500

- **Eugene Washington,** MD, Chancellor for Health Affairs at Duke University and President and CEO of the Duke University Health System—Director Compensation: $244,000

III. LEADERSHIP OVERVIEW

Stocked with directors from IT, retail, banking, and investment backgrounds—with only three directors possessing health care experience—Kaiser's board is positioned to run the organization as a profit-maximizing enterprise rather than as a nonprofit health care provider. *Note: Form 990 data for 2024 is not yet publicly available.*



Bank / Investment

33%

5 Members

Other Industries

(IT, Law, Transportation, Retail, Entertainment, Food)

47%

7 Members

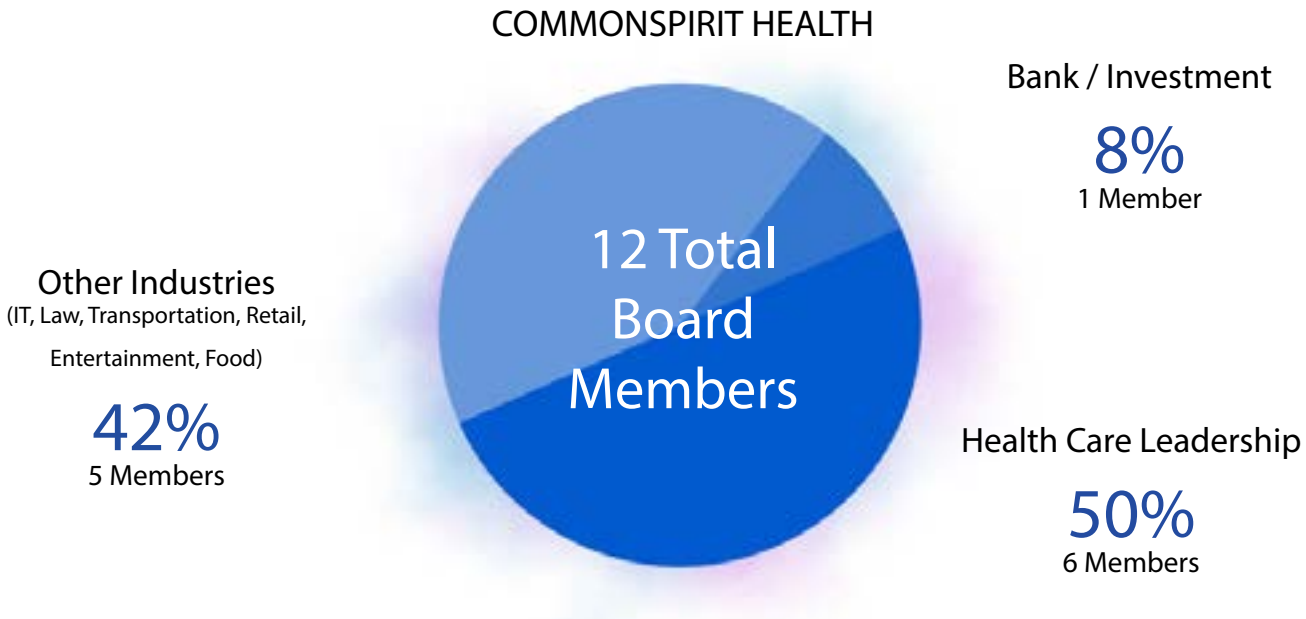
Health Care Leadership

20%

3 Members

Source: Analysis of financial reports of Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals and each of their Subsidiaries and Affiliates from 2020 to 2023. 2024 data from https://www.civilbeat.org/2025/10/strike-by-kaiser-permanente-workers-is-about-more-than-money.

III. LEADERSHIP OVERVIEW



Source: Analysis of Internal Revenue Service (IRS) Form 990 data for CommonSpirit Health for the 2023 calendar year or tax year beginning 0701-2023 and ending 06-30-2024.

In contrast, CommonSpirit Health's Board[54] of Stewardship had 12 board members that year, out of which half of its governing body has had extensive prior experience in health care and/or hands-on experience as a clinician:

8% with banking and investment backgrounds:

- **Christopher Lowney,** former Managing Director for **JP Morgan**—Director Compensation: $204,454

50% from health care leadership:

- **Antoinette Hardy-Waller,** MJ, BSN, RN, founder and CEO of The Leverage Network, a nonprofit organization dedicated to increasing the representation of African Americans in health care governance—Director Compensation: $159,375

- **Gary Kaplan,** MD, FACP, FACMPE, FACPE, Chair and CEO of Virginia Mason Health System—Director Compensation: $1,310,539 (Note: Kaplan also served as Senior Vice President[55] for CommonSpirit. The reported compensation appears to reflect that role and is consistent with the salaries of other CommonSpirit executives.)

III. LEADERSHIP OVERVIEW

Board of Directors (cont'd)

- **Gary Yates,** MD, family physician—Director Compensation: $154,244
- **Carolina Reyes,** MD, practicing Maternal Fetal Medicine specialist—Director Compensation: $143,750
- **Patrick Steele,** served as vice chair of the Dignity Health Board of Directors and is the former executive vice president and CIO of Delta Dental of California—Director Compensation: $207,891
- **Phoebe Yang,** former General Manager, Amazon Web Services, Health care— Director Compensation: $160,213

42% from IT, law, transportation, retail, entertainment, and food industries:

- **Angela Archon,** former chief operating officer in the Watson Health Division of IBM Corporation—Director Compensation: $158,603
- **Sister Ellen Dauwer,** SC, PhD, former college professor in Computer Information Systems and Educational Technology—Director Compensation: $0
- **Linda Medler,** retired USAF Brigadier General with more than 20 years of experience developing and executing cyber and technology strategies—Director Compensation: $159,092
- **Sister Barbara Hagedorn—**Director Compensation: $0

The contrast between the Board of these two large health care organizations is telling. When a nonprofit health care system is advised and led primarily by leaders whose careers have focused on amassing private wealth through business profits and investments, that institution may no longer put community-focused health care first.

Kaiser's leadership structure raises additional concerns. It could introduce potential conflicts of interest, reduce transparency in decision-making, and often lead to misaligned priorities that favor corporate or financial considerations over patient and community needs. The question becomes unavoidable: Has Kaiser chosen to elevate extractive profit over the services it is entrusted to provide?

III. LEADERSHIP OVERVIEW

Board of Directors (cont'd)

Kaiser's governance structure exhibits a series of significant investment entanglements that would raise concerns in any institutional finance environment—particularly for a primarily nonprofit health care system stewarding billions in patient-derived assets. Three current members of Kaiser's Board of Directors simultaneously hold board positions at publicly traded companies that appear within the Kaiser Permanente Group Trust portfolio, which manages company-controlled pension fund assets.[56] These allegations create potential structural conflicts of interest that could compromise the independence of investment oversight and elevate the risk of private benefit

Judith A. Johansen, JD

Johansen serves on the board of IDACORP, Inc., a company included in Kaiser's 2020 and 2022 Form 5500 filings[57], reveals a possible intersection between her responsibilities as a Kaiser director and her fiduciary duties to an organization benefiting from Kaiser's investment activity. In institutional governance, such overlap typically triggers heightened scrutiny, mandatory recusals, and a clear demonstration that investment decisions are insulated from insider influence.

Jenny J. Ming

Ming serves on the board of Levi Strauss & Co., a company reflected in Kaiser's 2020 and 2022 investment disclosures. Kaiser's investments thereby support the market position of an organization–where a sitting board member has fiduciary responsibilities. By financial industry standards, this raises questions about objective asset allocation and the independence of oversight, particularly when nonprofit resources are involved. Effective governance would require clear firewalls, documented recusal procedures, and independent validation of investment rationale.

David F. Hoffmeister

Hoffmeister represents the most complex case from an investment-governance standpoint. His board roles at Celanese Corporation, Glaukos Corporation, and ICU Medical, Inc. correspond directly to recurring Kaiser holdings across multipleyears (2022–2024). This may introduce significant governance risk, as the overlap spans several companies, multiple reporting cycles, and distinct sectors. In any institutional investment setting, this warrants formal conflict reviews, independent oversight, and enhanced scrutiny of decision- making processes to ensure investments are not influenced, directly or indirectly, by a director's external board affiliations.

III. LEADERSHIP OVERVIEW

Board of Directors (cont'd)

Additionally, Edward Y W Pei, who served on the board in 2023, is Executive Vice President at Hawaii Bankers Association and former Executive Vice President-Consumer Banking Group at First Hawaiian Bank. First Hawaiian Bank is a member bank of Hawaii Bankers Association and is included in Kaiser's 2020 and 2022 Form 5500 filings.[58]

Taken together, these cases reveal a governance environment in which Kaiser Permanente's investment portfolio significantly overlaps with the corporate affiliations of its own directors. In the financial industry, such arrangements call for elevated oversight, conflict-mitigation protocols, and independent review. For a largely nonprofit health care system, the implications are even more consequential. These entanglements raise a foundational question: Are Kaiser's investment decisions guided by patient-centered duty or by corporate influence driven by opposing values? The integrity of nonprofit financial stewardship relies on insulating investment decisions from insider influence. Kaiser's current structure makes that line increasingly difficult to discern.

IV. FRAUDULENT PRACTICES AND LAWSUITS

For all its claims about commitment to community health and patient well-being, Kaiser has faced repeated allegations of institutional misconduct.[59] One of the most serious allegations against Kaiser Permanente was uncovered by Kaiser employees raising alarms under the False Claims Act.

According to a New York Times report in October 2022, the "health system Kaiser Permanente called doctors in during lunch and after work and urged them to add additional illnesses to the medical records of patients they hadn't seen in weeks. Doctors who found enough new diagnoses could earn bottles of champagne or a bonus in their paycheck."[60]

Moreover, other reporting has explained that Kaiser has "faced federal lawsuits alleging that efforts to overdiagnose its customers crossed the line into fraud."[61] These allegations remain active and unresolved, with recent reports stating that the "Justice Department and Kaiser Permanente are nearing a deal in their behind-the-scenes negotiations over the government's claim that the California health care giant bilked Medicare out of $1 billion." On Jan.14, Kaiser agreed to $556 million settlement. [62]

"Doctors who found enough new diagnoses could earn bottles of champagne or a bonus in their paycheck."

New York Times, October 2022

IV. FRAUDULENT PRACTICES AND LAWSUITS

The Medicare fraud allegations involved a Kaiser scheme that deliberately pressured providers to falsify and manipulate medical records to illegally inflate federal Medicare payments "to rake in more cash."[63] It is alleged that, prioritizing money, Kaiser was willing to sacrifice patient care and the accuracy of patient medical records for financial gain. This same set of priorities fuels Kaiser's resistance during negotiations with its health care professionals, where reasonable patient-centric demands for adequate staffing and patient time are summarily rejected.

Listed below are a series of lawsuits and additional allegations of fraudulent activities:

- A $200 million settlement[64] (2023) for unlawful delays in mental health care.
- A $41 million[65] jury verdict (December 2023) awarded to a nurse in a discrimination and wrongful termination lawsuit against Kaiser Permanente.
- A $49 million[66] settlement (September 2023) with the state of California for illegally dumping medical waste and private patient records. Medical waste poses serious health hazards, and for an organization that claims to champion community health, this conduct would be not only illegal, but also profoundly hypocritical.
- An $819,500 regulatory fine[67] (April 2025) for slow complaint responses.
- Endangering a patient in a research study, resulting in two Kaiser researchers being suspended[68] following an internal investigation (January 2025) that found they broke rules and put some research volunteers at risk for ethics violations.
- Mental health workers[69] (April 2025) accused Kaiser of illegally using clerical staff and algorithms to triage suicidal patients.

That is roughly $356 million paid out for these settlements. For lawmakers, regulators, patients, other stakeholders, and the American public at large, the mandate is clear: Ensuring Kaiser fulfills its nonprofit obligations is not merely a matter of principle—it is a matter of protecting patient safety, maintaining system reliability, and preventing taxpayer-subsidized institutions from prioritizing a private institute's financial gain over public health.

V. FINANCIAL PRIORITIES AND SPENDING ANALYSIS

Kaiser Permanente maintains an ever-expanding global investment footprint, which supports countries and companies with practices that are often directly opposed to its stated mission (see below). This also begs the question: Why is a U.S. nonprofit health care organization, subsidized by U.S. taxpayers, investing those funds in foreign countries and with foreign entities instead of within the United States? Kaiser's IRS Form 990-T and the Kaiser Permanente Group Trust Form 5500 for 2020,[70] show that Kaiser's investment portfolios included:

- Investments in over 20 foreign countries, including Russia, Turkey, Saudi Arabia, and the Philippines
- Holdings of $65 million in Russian government issues and additional investments in rubles and Russian oil and gas
- OPEB (Other Post-Employment Benefits) fund concentration risk: Approximately $5.7 billion of the OPEB fund's fair value is tied to a single investment, exposing the Plan to heightened risk if that investment declines in value

KAISER PERMANENTE'S FOREIGN INVESTMENTS
IN GOVERNMENT ISSUES AND ASSETS

Some examples of Kaiser's IRS filings show investments in over 20 foreign countries, including Russia, Turkey, Saudi Arabia, Philippines, Republic of Congo, Peru and Argentina.

V. FINANCIAL PRIORITIES AND SPENDING ANALYSIS

Kaiser's partnerships include funds managed by Elliott International Capital and Elliott Investment Management,[71] led by billionaire Paul Singer—one of the most controversial and hardline activist investors in the world. Singer built a multibillion-dollar fortune through aggressive sovereign-debt strategies that have reportedly destabilized economically vulnerable nations, earned him the label of a "vulture capitalist," and drawn international scrutiny for tactics critics describe as predatory and extractive.[72] His fund has legally pursued countries such as Argentina, Peru, and the Republic of the Congo for years, refusing restructuring agreements and instead suing governments until they capitulated—turning distressed public debt into massive private profit. Singer's model has been widely criticized for prioritizing returns at any human cost, draining public resources from nations already in crisis. This is not standard nonprofit stewardship—this is corporate financial engineering on a massive international scale.

Credit: REUTERS/Jeenah Moon

V. FINANCIAL PRIORITIES AND SPENDING ANALYSIS

Kaiser's Investment in Elliott: Financing the Singer–Manhattan Institute Policy Machine

Kaiser's money goes beyond generating returns, and finances a political "policy machine" with harmful downstream impacts on public institutions and vulnerable communities. As noted, Kaiser's investments in Elliott Management directly connect them to Paul Singer, the billionaire "Vulture Capitalist"[73] and "Doomsday Investor"[74] who served as CEO of Elliott Management and Chairman of the Manhattan Institute, an extreme right-wing think tank. Betsy DeVos became Chair of the Manhattan Institute's Board, succeeding Paul Singer.[75]

However, through Singer, Elliott Management funds the Manhattan Institute.[76] This organization pushes policies that include austerity for public institutions, deregulation for corporations, tax cuts for the wealthy, and the privatization of education.[77] The Institute promotes the rollback of LGBTQ protections and urge restrictions on gender-affirming care, publishing several articles and papers designed to influence legislation in that direction.[78]

The Institute also wages culture-war campaigns targeting civil rights and racial minority communities.

One example of this extreme agenda is in the Manhattan Institute's publication, **How to Regulate Critical Race Theory in Schools: a Primer and Model Legislation | Manhattan Institute.**[79]

The publication calls for the suppression of classroom discussions of systemic racism, thereby promoting a distorted and misleading understanding of American history and civil rights. These policy positions create hostile learning environments for students of color, erode academic integrity and jeopardize student well-

The Manhattan Institute uses its framing of Critical Race Theory to discredit public schools and to push its agenda of privatization and charter schools. A senior fellow at the Institute, Christopher Rufo, has spoken publicly about "Laying Siege to the Institutions," calling for a "siege strategy" and "narrative war" to erode confidence in public schools. Rufo argues that advancing a universal school choice agenda requires "universal public-school distrust"— urging supporters to be "ruthless and brutal" in pursuit of that goal.[80]

V. FINANCIAL PRIORITIES AND SPENDING ANALYSIS

Kaiser's Investment in Elliott: Financing the Singer–Manhattan Institute Policy Machine (cont'd)

Notably, several states—including Texas, Florida, Tennessee, and Oklahoma—have enacted legislation similar to Manhattan's Critical Race Theory model bill, magnifying the national impact of these harmful policies.[81]

By channeling patient and member dollars into Elliott Management, Kaiser executives help underwrite the Manhattan Institute's ideological agenda, which directly undermines the social conditions and civil rights protections that support community health. In doing so, Kaiser's investments conflict with its stated mission as a community-based health care provider committed to improving the social determinants of health.

V. FINANCIAL PRIORITIES AND SPENDING ANALYSIS

Private-Prison Exposure: Kaiser Profits From the Expansion of I.C.E. Detention Centers

Kaiser Permanente has investment ties to some of the country's darkest corners: private prisons and the immigration-detention industry. CoreCivic and The GEO Group[82]—the two dominant private-prison corporations in the United States—derive substantial revenue from federal detention contracts, particularly through the U.S. Immigration and Customs Enforcement (ICE). Kaiser Group Trust has grown its assets in part by profiting from the dispossession of human liberty, which disproportionately affects people of color.

Detention centers across the nation, including seven facilities in California, have been repeatedly documented for poor conditions, medical neglect, and civil-rights violations.

A recent U.S. Senate investigation underscored just how deep these failures run, highlighting Stewart Detention Center in Georgia, operated by CoreCivic, as one of the most troubling examples.

The report found 80 credible cases of medical neglect, including detainees denied insulin[83], left without medical care for days[84], and one man who suffered a heart attack after days of untreated chest pain.[85]

> "They go in alive, and some of them come out in a box."

Mildred Pierre, fiance of Rodney Taylor, taken into ICE custody just days after his engagement. Taylor, a double amputee, has been in custody for a year.[86]

Credit: Sarah Kallis/GPB News
Mildred Pierre calls for the release of Rodney Taylor at a peaceful rally outside of the Atlanta ICE field office.

V. FINANCIAL PRIORITIES AND SPENDING ANALYSIS

Private-Prison Exposure: Kaiser Profits From the Expansion of I.C.E. Detention Centers (cont'd)

A Department of Homeland Security employee reported that, "ambulances have to come almost every day." Investigators also documented widespread deprivation of food and clean water, including expired milk, foul-tasting water, and meals too small to meet basic nutritional needs. Additionally, CNN reported "worms and mold in the food", "threats of family separation by officers and staff", and weak children "crying because they are so hungry" at an ICE detention center in Dilley, Texas, run by CoreCivic.[87]

Credit: Yazmin Juarez

Mariee Juárez, 21 months old, died after allegedly developing a respiratory infection that was not properly treated at South Texas Family Residential Center, an ICE detention facility operated by **CoreCivic.**[88]

V. FINANCIAL PRIORITIES AND SPENDING ANALYSIS

“They treat us like dogs in cages!”

A detainee at the Adelanto ICE Processing Center, operated by The GEO Group in San Bernardino, CA[89]

The GEO Group runs the largest detention center in California, known as Adelanto, which has been at the center of numerous serious complaints[90,91,92], from federal inspectors and lawmakers that detainees have been routinely denied medical care and other basic human necessities.

One detainee went two weeks without his prescribed medications and suffered a stroke-like syndrome because of the lapse in care, and another with frostbite lost parts of six fingers after being denied timely specialist care.[93] A detainee who required diabetic medication twice per day,[94] reported receiving it only twice in 10 days, leaving him at risk for diabetic shock. Detainees were not given their medication for asthma and urinary conditions.[95]

Several detainees undergoing mental health challenges, such as panic attacks and anxiety were denied mental health services.[96]

After the June 2025 ICE raids in Los Angeles, U.S. Rep. Judy Chu (D-Monterey Park), and four other California lawmakers toured the facility.[97] They learned that detainees were:

- Held for 10 days without a change of clothes, including underwear or socks
- Denied sufficient meals and safe drinking water
- Prevented from using phones to contact their families or legal counsel
- Forced to sleep on common-area floors without pillows or blankets

Additional reports detail:

- Unsanitary bathrooms and showers
- Trash accumulation
- Chronic understaffing that left detainee requests for water, clothes, or medical attention unanswered

VI. FINANCIAL PRIORITIES AND SPENDING ANALYSIS

These findings paint a harrowing picture of the human rights abuses perpetrated by the private prison operators. Former California Assemblyman and current Attorney General Rob Bonta has warned that people held inside these facilities "are hurt, abused, neglected."[98]
In addition he noted, [t]hese are for-profit private entities, their fiduciary duty is to Wall Street and their shareholders . . . literally profiteering on the backs of Californians."

California Governor Gavin Newsom issued a clear condemnation, stating, "for-profit prisons do not reflect our values"[99] and promised to "end the outrage of private prisons once and for all" in California.[100]

In sharp contrast, Kaiser Permanente, through its decisions to invest in CoreCivic and The GEO Group, has effectively supported the success of these private prisons and immigrant detention centers—a betrayal of the values Kaiser claims to uphold.[101]

> "[t]hese are for-profit private entities, their fiduciary duty is to Wall Street and their shareholders…literally profiteering on the backs of Californians."[98]
> —California Attorney General Rob Bonta

Predatory Lenders

Kaiser's investment portfolio includes holdings in Enova International,[102] the parent company of CashNetUSA and NetCredit—a Chicago-based lender specializing in short-term, high-cost online loans. Enova's products are frequently marketed to desperate people already in financial distress. Its loans often carry annual percentage rates between 100% and 400% or higher, depending on the state, rates that can exceed those charged by loan sharks. These terms create conditions that can trap borrowers in long-term cycles of debt rather than providing temporary relief.[103]

In 2023, the Consumer Financial Protection Bureau fined[104] Enova $15 million for making unauthorized withdrawals from consumer bank accounts and billing practices that violated federal consumer protection rules. Advocacy groups have raised concerns about payday lenders' targeted advertising in low-income neighborhoods, arguing that this approach exploits financial desperation and disproportionately harms minorities.[105]

V. FINANCIAL PRIORITIES AND SPENDING ANALYSIS

Consumer watchdogs note that Enova's business model depends heavily on repeat borrowing and refinancing—the company profits most when borrowers cannot escape debt.[106]

Kaiser's investment in this business model raises serious questions about its stated commitments[107] to promote financial well-being, reducing inequities, and supporting the economic foundations of community health.

Fossil Fuels and Fracking

Kaiser's financial portfolio shows investment holdings in major fossil-fuel corporations such as Occidental Petroleum[108] and ConocoPhillips,[109] two of the most aggressive fracking operators in the United States. Hydraulic fracturing has been repeatedly linked[110] in peer-reviewed research, to elevated rates of birth defects, childhood asthma, respiratory disease, multiple cancers, liver toxicity, endocrine disruption, groundwater contamination, and increased hospitalization rates for communities living near drilling sites.

ConocoPhillips and Occidental have continued expanding fracking operations even as scientific bodies—including the National Center for Biotechnology Information—warn of escalating health and environmental consequences.[111] Studies from state health departments in Colorado[112] and Pennsylvania[113] have documented increased congenital heart defects, neural-tube defects, preterm birth, and spikes in childhood leukemia near fracking wells.

Despite this evidence, these companies persist in pushing high-intensity extraction projects that disproportionately harm low-income, rural, and Indigenous communities.[114] Kaiser's financial participation in corporations whose core business directly contributes to documented, preventable disease is not merely inconsistent with its health care mission—it actively undermines it.

V. FINANCIAL PRIORITIES AND SPENDING ANALYSIS

Fossil Fuels and Fracking (cont'd)

For a largely tax-exempt health system that claims a mission of community well-being, holdings in private-prison or detention companies raise legitimate questions about alignment between financial practices and public health obligations.

This is part of an insidious and systemic operating mindset and investment strategy that has abandoned morals, its health care providers, patients, and the communities in which they operate in favor of hoarding vast financial reserves.

Credit: Human Rights Watch

A view of a refinery corridor where nearby neighborhoods face hazardous levels of air pollution, which disproportionately affects the health of low-income communities and people of color.

VI. DISPROPORTIONATE EFFECT ON LOW-INCOME COMMUNITIES AND PEOPLE OF COLOR

Publicly, Kaiser Permanente presents itself as a national leader in diversity, equity, and inclusion. Its promotional materials highlight a workforce with high representation of women, Black, Latino, and Asian employees, a diverse advisory board, and recognition by organizations like DiversityInc for inclusive business practices. Kaiser executives frequently herald this narrative, emphasizing an institutional commitment to eliminating health disparities. As CEO Greg Adams stated on the 2022 HLTH Mainstage, "In 2007 our board took the position that we would own and we would lead the nation in eliminating health disparities... and if you look at where we are with African Americans, Asian Americans, Latinx communities, we've closed the care gap, and so it's just a part of who we are.[115]

The reality behind these claims tells a different story. Kaiser's documented overbilling of Medicare Advantage[116] strikes directly at vulnerable populations. Medicare primarily serves elderly and disabled patients.[117]

When Kaiser unlawfully siphons money from this program, it is extracting resources from communities whose health care access depends on those funds.

Kaiser's financial decisions raise further questions about its alignment with the needs of low-income communities and communities of color. Instead of directing surplus revenue and tax-exempt advantages toward local reinvestment, Kaiser deploys vast sums in foreign bonds, hedge funds, and high-risk alternative markets. Every dollar sent abroad is a dollar not invested in marginalized neighborhoods Kaiser publicly claims to uplift.

Kaiser's operational footprint also mirrors extractive corporate behavior. Its alleged Illegal or improper dumping of medical waste disproportionately endangers low-income neighborhoods, where environmental protections are weakest and residents already face elevated rates of cancer and asthma.[118]

VI. DISPROPORTIONATE EFFECT ON LOW-INCOME COMMUNITIES AND PEOPLE OF COLOR

Kaiser's investment holdings also tie it to industries whose harms fall overwhelmingly on communities of color. Private prisons and immigration detention facilities—where abuses and medical neglect are documented at length— are disproportionately filled with Black, Latino, and immigrant detainees.

Financial exposure[119] to companies like The GEO Group and CoreCivic through investment holdings means profiting from the mass incarceration and systemic mistreatment of these populations.

Similarly, investments in predatory lenders such as Enova enable debt-cycle practices that trap low-income and minority borrowers in financial hardship.[120]

Kaiser has holdings in fossil-fuel and fracking companies whose actions contribute to environmental degradation that overwhelmingly affects poor communities.

Fracking wells, chemical spills, and air-quality violations cluster in zip codes largely populated by people of color, driving cancer risk, hypertension, and chronic disease.[121]

Taken together, Kaiser's actions reveal a profound contradiction. The organization publicly embraces the language of equity, but its financial strategies, risk-taking investments, and operational choices could be seen as offloading environmental, financial, and health burdens onto the poorest and most racially marginalized communities in the United States.

What Kaiser markets as "closing the care gap" is belied by an investment strategy that perpetuates the very disparities it claims to eliminate.

VII. KAISER'S ATTACK ON ITS EMPLOYEES AND THE VOICE OF ITS CAREGIVERS

Henry J. Kaiser believed unions were "necessary" and supported them "100%."[122] His vision, developed with Dr. Sidney Garfield, was affordable, worker-centered, prevention-based health care. That legacy carried forward to 1997, when, in response to extreme financial distress and labor unrest, the parties established the Labor-Management Partnership (LMP), a historic model of shared decision-making and transparency at every level of Kaiser Permanente. The LMP helped propel the organization to national leadership in patient quality, satisfaction, and innovation. From its inception, the LMP honored Henry Kaiser's worker-centered legacy.

Over the past 12 years, Kaiser has sharply abandoned those principles. A recent incident underscores how parts of the organization apparently view its own workforce. As reported[123] by Nurse Erica, RN, BC in a viral social media video, a Kaiser Permanente emergency physician sent a group text message calling health care workers "parasites."

In the same text message, the physician also bluntly stated, " C-Suite is figuring out how to replace its entire staff into a non-union model."[124] After the message surfaced, the doctor issued an email apology, and Kaiser officially denied any such intention. For many employees, this episode reflects a broader pattern: leadership that minimizes worker concerns and fails to treat its health care professionals with the respect they deserve.[125]

Kaiser touts its internal "Value Compass"—Quality, Service, Access, and Affordability—with patients at its center.[126] But an examination of how Kaiser executives actually steer the organization reveals a different story. Instead of honoring Henry Kaiser's worker-centered foundation or the collaborative spirit of the LMP, Kaiser's current leadership has drifted far from its history, its stated mission, and the workforce that built its success.

VII. KAISER'S ATTACK ON ITS EMPLOYEES AND THE VOICE OF ITS CAREGIVERS

Kaiser's Introduction of Two-Tier Structures: The Attack on Labor Begins

An employer that truly views its unions as partners does not try to weaken or eliminate workers' pensions. Yet Kaiser Permanente has repeatedly attempted exactly that over the past decade.

After leaders and workers broke away from SEIU-UHW and formed the National Union of Healthcare Workers (NUHW) in 2009,[127] Kaiser quickly targeted the retirement security of these health care providers.

It demanded that NUHW accept a two-tier pension proposal under which employees doing the exact same job would receive no pension based solely on their date of hire.

After NUHW continuously rejected the proposal, Kaiser in 2015 refused to continue bargaining and unilaterally imposed its two-tier pension on NUHW members in Southern California.[128]

Critics argued that this was an overly hostile attack on the caregivers — an intentional effort to divide the workforce.

Kaiser Continues Attack Against Unions in 2021 Alliance Bargaining

In 2021, at the height of the COVID-19 pandemic, Kaiser Permanente demanded a two-tier wage system in national contract bargaining with the Alliance of Health Care Unions — an extraordinary concession amounting to a 26% reduction for new hires.[129]

As a result, caregivers — who had just endured a year and a half of mass death, PPE shortages, trauma, fear of infecting their families, and unprecedented burnout —faced an attack on their own livelihoods from the organization they had sacrificed to support.[130]

VII. KAISER'S ATTACK ON ITS EMPLOYEES AND THE VOICE OF ITS CAREGIVERS

Kaiser Continues Attack Against Unions in 2021 Alliance Bargaining

The context makes Kaiser's demand even more striking. Several unions, including about 24,000 UNAC/UHCP nurses and health care professionals, had deliberately chosen not to open their local contracts that year, forgoing negotiations to maintain patient care stability during the ongoing public health emergency. It was an act of sacrifice. Instead of recognizing that commitment, Kaiser interpreted it as vulnerability—and went on the offensive, demanding for months that the unions accept its two-tier wage proposal.[131]

By October 2021, more than 32,000 Alliance members had authorized strikes and were set to walk out on Nov. 15 in what would have become one of the largest health care strikes in recent American history. The strike was narrowly averted just two days before it was set to begin, when Kaiser finally withdrew its two-tier demand.[132]

Rising Strikes and Service Disruption (2019–2024)

Understanding that strikes cause a disruption to operations, unions inside the LMP went 25 years without a single strike. LMP unions delivered stability with continuity of care for a quarter of a century.

That changed as Kaiser's labor relations approach grew increasingly hostile. Beginning in 2021, the organization added attacks on workers' pensions[133] to its two-tier wage demands in Alliance negotiations, while displaying open disrespect for caregivers.

VII. KAISER'S ATTACK ON ITS EMPLOYEES AND THE VOICE OF ITS CAREGIVERS

Here is a list of strikes and service disruptions Kaiser has invited since the near-strike by the Alliance of Health Care Unions in October 2021:

- **February – April 2022:** 500 UNAC/UHCP nurses' aides, respiratory therapists, licensed practical nurses, housekeepers, and others struck against Kaiser's Maui Health System.[134]
- **July 2022:** 2,400 NUHW mental health professionals strike over staffing and patient access.[135]
- **October 2023:** 75,000 workers with the Coalition of Kaiser Permanente Unions strike for three days. Issues included safer staffing ratios.[136]
- **September 2024 – May 2025:** NUHW's 2,400 mental health professionals strike for six months seeking equity for mental health care and physical health care within the Kaiser system, as required by California law.[137]
- **November 2024:** 900 UNAC/UHCP nurses, pharmacists, physical, speech, and occupational therapists, imaging technicians, clerical staff, and others strike against Kaiser's Maui Health Systems over issues including life-threatening nurse shortages in the emergency department.[138]
- **September 2025:** 600 UNAC/UHCP midwives and nurse anesthetists strike for one day in Northern California to highlight drastic patient care issues and Kaiser's cuts to their wages and retirement benefits.[139]
- **October 2025:** 46,000 workers for the Alliance of Health Care Unions, including nurses and numerous other classifications, strike Kaiser nationwide over patient care, staffing, retirement benefit cuts, compensation, and other issues.[140]

Credit: Nelvin C. Cepeda / The San Diego UnionTribune

Kaiser Permanente caregivers launch a 5- day strike in pursuit of safer staffing for their patients.

These were not isolated disputes; they were a collective response to what many workers claimed was a deteriorating work environment and a leadership philosophy fundamentally at odds with Kaiser's own Value Compass. Rather than "Best Place to Work,"[141] frontline caregivers faced frustration, burnout, and profound dissatisfaction with an employer that appeared to have lost its way.

VII. KAISER'S ATTACK ON ITS EMPLOYEES AND THE VOICE OF ITS CAREGIVERS

Rising Strikes and Service Disruption (2019–2024)

For years, Kaiser negotiated first contracts—even tough ones—in good faith. Newly organized groups were welcomed into existing agreements or brought in through straightforward negotiations. That era is over.

The newest Kaiser professionals to unionize with UNAC/UHCP—Northern California Certified Nurse Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs), Acupuncture Providers, Physician Assistants (PAs), along with Southern California Child Life Specialists, and) and Hawaii Certified Registered Nurse Anesthetists have run headfirst into a very different Kaiser: one that treats new organizing as a threat to be crushed.

In Northern California, Kaiser began bargaining with the newly unionized midwives by proposing cuts to their retirement and health benefits, as well as a 17% wage reduction.[142] Even worse, in negotiations with a tiny group of 12 Child Life Specialists, Kaiser demanded the elimination of pensions for current and future hires, after they chose to join a union.

Why is Kaiser attacking midwives, child life specialists, CRNAs, and PAs? These are its own employees, caring for its own patients. The pattern suggests a deliberate strategy: punish workers for choosing union representation and discourage others from doing the same. Retaliation? As the infamous text from the physician put it, "*the C-Suite has a plan.*"

Kaiser's Attack on Labor Will Threaten Future Health Plan Membership Growth

Kaiser Permanente's Labor and Trust Funds webpage states: "Our commitment to labor runs as deep as our commitment to delivering high-quality, affordable care…Every day, Kaiser Permanente collaborates with our union workers to improve what we do. It's how we got our start."[143]

Those fine words were once actually true. Not only did Kaiser get its start providing health care to Henry J. Kaiser's unionized workforce and their families, but its growth has been enormously dependent on its pro-labor reputation, with labor unions, as a rule, writing Kaiser insurance into their union contracts as at least one—and often the only—choice of health care provider for their members. A vast chunk of Kaiser Permanente's membership and revenue comes from labor trust funds.

VII. KAISER'S ATTACK ON ITS EMPLOYEES AND THE VOICE OF ITS CAREGIVERS

Kaiser's Attack on Labor Will Threaten Future Health Plan Membership Growth

Kaiser's turn away from its historic pro-labor stance toward union-busting and divisive, concessionary bargaining will undermine the organization's patient membership base and, in turn, threaten its income stream.

If Henry J. Kaiser and Dr. Sidney Garfield set a true north of patient-centered, worker-focused care built in partnership with a unionized workforce, today's leadership has abandoned it. Kaiser's pursuit of profit maximization, service disruption, and open attacks on its own workers cannot be squared with its Value Compass. These actions are irreconcilable with "Best Place to Work," "Best Service," or "Patient and Member Focus." The needle of Kaiser's Value Compass isn't just pointing off course—it's spinning out of control.

VIII. DECLINE OF PATIENT CARE AND THREAT TO PATIENT SAFETY

"I took my father in to get some concerning symptoms checked out. I asked for a specific test to rule out something really serious. The doctor looked me straight in the eye and said the test was 'too expensive,' and that if they ordered tests like that for every patient, they'd have to start raising member premiums. Then he brushed it off—saying he didn't think it was necessary anyway.

I was livid. I said, 'My whole family has been Kaiser members for over 18 years. What about the thousands of dollars we pay every year? What about actually caring for your patients?'

The doctor didn't even blink. No concern whatsoever."

Kaiser Permanente patient, Southern California

VIII. DECLINE OF PATIENT CARE AND THREAT TO PATIENT SAFETY

Instead of aspiring to provide its patients with the best possible care, Kaiser has focused heavily on rapid "throughput" appointment models, virtual visits, and automated triage systems designed to push patients in and out of the system as quickly as possible.[144]

This approach mirrors what critics call the "McDonaldization of Healthcare,"[145] which describes a system where efficiency, predictability, standardization, and centralized control take precedence over clinician judgment, professional autonomy, and individualized care.

While these processes may look appealing on paper–particularly to Kaiser's financial leadership team–frontline clinicians report that the reality is antithetical to delivering proper and ethical patient care. This approach comes at a high price: Increasing rigidity and the erosion of diagnostic nuance and rigor.

Critics argue that complex cases are forced into one-size-fits-all treatment pathways. Clinicians are left with concerning restrictions to exercising their professional judgment, and the uniqueness of each patient is treated as an operational inconvenience rather than a clinical reality. The result is care that cares more about profit than people.

Meanwhile, visit times have become so compressed that meaningful interaction and relationship-building with patients is difficult or impossible. Clinicians and patients report feeling rushed, with time constraints that limit careful evaluation and attention to detail.

Registered nurses and health care professionals further warn that productivity quotas are playing an increasingly outsized role in clinical decision-making. Staff feel pressured to meet productivity metrics rather than deliver truly patient-centered outcomes.

> "They rush patients through the ED [Emergency Department] way too fast and it's caused multiple patient injuries and deaths. Kaiser is always getting sued and rightfully so because they don't care about their patients or their staff. They lie to the public about how great they are and we aren't supposed to talk about any truths about Kaiser."
>
> Kaiser Permanente health care provider, Southern California

VIII. DECLINE OF PATIENT CARE AND THREAT TO PATIENT SAFETY

Care decisions are being increasingly shaped by cost algorithms rather than medical need, while performance targets are tied to financial benchmarks rather than patient outcomes. In other words, what can be counted becomes more important than what actually counts. Kaiser functions as both an insurer and a care provider. And unlike traditional insurers, Kaiser rarely needs to issue formal claim denials. Instead, its integrated model allows for a more invisible form of care restriction. Physicians may simply refrain from ordering certain tests, referrals, or services.

This raises a fundamental question: When insurance coverage and care delivery are unified, does the system avoid claim denials by approving more care, or by ensuring fewer claims are submitted in the first place?

Chronic Short-Staffing

In December 2023, 53-year-old Francisco Delgadillo, arrived at Kaiser Permanente Vallejo Emergency Department, suffering severe chest pain. Despite symptoms of a potentially life threatening cardiac condition, he was forced to wait for more than eight hours without meaningful reassessment or treatment, and ultimately collapsed and died in the hospital lobby.

The Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services (HHS), and the California Department of Public Health found critical deficiencies in the hospital's emergency department operations, including a failure to provide adequate nursing coverage. At times 30-40 patients were in the ER waiting area with no systematic oversight or clinical evaluation.

Investigators further determined that these deficiencies were not an isolated incident. Frontline workers had repeatedly raised concerns in the days leading up to the incident, circulating a petition demanding safe staffing levels just days before Mr. Delgadillo's death. However, the governing body of the hospital failed to meet the staffing levels necessary to fulfill federal regulatory requirements.[146]

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Perhaps the most alarming pattern, according to Kaiser health care providers and patients, is that Kaiser Permanente continues to keep its facilities severely understaffed. Despite legally required safe staffing ratios designed to ensure adequate patient care, patients and providers report that Kaiser repeatedly fails to meet their legal requirements.

Care teams are overworked, burned out, spread dangerously thin, and unable to provide the standard of care their patients deserve.

Patients report dangerous wait times for basic care and urgent appointments. Many describe being brushed off with vague instructions to "go to urgent care" regardless of clinical need.

When Kaiser consistently operates below adequate staffing levels, essential patient needs fall through the cracks—forcing friends and family to fill gaps, and often leaving patients without basic care or dignity.

The current labor dispute between UNAC/UHCP and Kaiser centers on these concerns. For years, frontline health care workers have reported severe exhaustion and workloads that far exceed safe standards, warnings they say that have been repeatedly ignored, although they could mean the difference between life and death.

"It's heartbreaking to hear patients calling, crying that they are in pain and can't get in to get the surgery they need. Or that they are not feeling well and don't want to keep going to Urgent Care or ER. They just want to see their own PCP [primary care provider] who is booked up for the next two months."

Kaiser health care provider Tustin, CA

"My husband has been in the hospital for 19 days here at Woodland Hills Kaiser… Because of lack of staffing, I have had to do numerous things that normal staffing would be doing, including changing a pure wick [catheter], fixing the batteries connected to the IV lines… changing his gown, changing his bedding and daily sponge baths. The list goes on and on. The hospital is dirty due to lack of staffing as well."

Community member, Camarillo, CA

VIII. DECLINE OF PATIENT CARE AND THREAT TO PATIENT SAFETY

Understaffing[147] increases risk of infection, prolongs recovery times, and results in avoidable medical deterioration. It has already contributed to multiple patient safety complaints, regulatory scrutiny, and legal action.

Below is a list of additional documented patient safety concerns:

- An $819,500 regulatory fine[148] (April 2025) for slow complaint responses.
- Reports that Kaiser Permanente is not paying enough to incentivize and retain enough Certified Wound Ostomy Nurses (CWONs), highly trained specialists responsible for treating complex or hard to heal wounds with advanced endoscopic technology.[149] As a result, instead of having these critical specialists at the bedside when urgently needed, at times, medical staff without proper training report that they have been forced to call a CWON for guidance by phone. This practice could be dangerous for patients who rely on precise, in-person clinical care.
- A major system outage[150] (May 2025) that forced pharmacies to revert to manual processes, jeopardizing timely access to medications.

> "My husband is currently an inpatient at Kaiser Zion being treated for a serious infection involving his transplanted kidney & an E-coli infection. Since our arrival via the ER… it has taken an extensive amount of time for each facet of his care. As his spouse & caregiver I have felt extremely uncomfortable leaving him alone in Kaiser's care!! From being left on a bedpan for nearly an hour! Meanwhile our membership rates have steadily climbed at a STAGGERING rate! Fed UP!! David [my husband] has been a Kaiser member for over 40 years!! We are seriously considering changing our health care plan! I fear that my husband's life has been put in jeopardy due to this barbaric [low] staffing!"
>
> Community member, San Diego

- California DMHC found Kaiser systematically failed to provide timely, adequate behavioral-health care—long waits, missed referrals, and inappropriate reliance on group therapy—resulting in a $200 million enforcement action for widespread access violations.A major system outage (May 2025) that forced pharmacies to revert to manual processes, jeopardizing timely access to medications.[151]

VIII. DECLINE OF PATIENT CARE AND THREAT TO PATIENT SAFETY

- October 2023[152] and April 2024[153] data breaches impacted patient and employee information.
- In July, registered nurses across California held a public vigil in San Francisco to protest Kaiser's decision to eliminate certain gender-affirming care for individuals under age 19—an age threshold that frontline clinicians deemed medically arbitrary and inconsistent with research published by the Kaiser Family Foundation.[154]
- As Sydney Simpson, RN,[155] stated: "Kaiser's own foundation has put out research on the efficacy of this care. The evidence is there that this care is safe and effective. What's unsafe and ineffective is caving to political pressure that puts our patients at risk. We won't stand for it, and it's why we're taking action together."

Throughout August and September of 2025, nurses statewide issued additional warnings documenting decisions that undermined clinical standards, restricted access, and failed to respect evidence-based practice - even going as far as staging an informational picket in support of better wages and increased staffing on their day off from work.[156]

Kaiser appears to respond to each crisis only after public scrutiny, legal exposure, or regulatory action forces its hand. These reactive fixes do not address the underlying problem: a corporate culture driven by cost containment, asset protection, and institutional expansion—not patient care or ethical responsibility.

Kaiser Permanente has the financial capacity and operational scale to deliver exceptional care. However, the data and firsthand accounts in this report reveal a system increasingly optimized for standardization and cost containment at the expense of clinical judgment and staffing safety. When workforce reductions and rigid protocols become embedded business strategies, preventable harm to patients becomes an operational norm. This is why employees and their union, UNAC/UHCP, have no choice but to demand meaningful change that moves beyond the empty promises of the past and into real practice in the future.

The risks are clear: diminished patient care outcomes and trust, deteriorating working conditions and employee morale, heightened regulatory exposure, and accelerating reputational damage. Kaiser's challenge now is not a matter of resources–it is a matter of priorities. The longer it delays meaningful reform, the higher the human cost—and the more irreversible the damage becomes.

IX. CONCLUSION

This report raises grave concerns: Kaiser's leadership structure and profit-oriented board composition, potential conflicts of interest, investment strategies tied to socially destructive corporations, unfair compensation practices—and most critically, harmful understaffing. Unless these problems are urgently and decisively addressed, the consequences for patients and communities will be dire.

Kaiser's actions carry significant implications far beyond its own system. As California's largest provider, Kaiser Permanente does not merely participate in the market, it sets the benchmark. When the industry leader normalizes the rapid deterioration of patient care, others inevitably follow. And when Kaiser continues to underpay and undervalue its own health care workforce—refusing to pay wages that keep up with the cost of living and driving experienced providers out of the field–it fuels a cycle of burnout, turnover, and a sharp decline in recruitment that reverberates across hospitals nationwide.

The writing is on the wall: Deepening nursing shortages, reduced patient access, and longer wait times for care, even in urgent situations. These could become the new normal.

At the same time, Kaiser Permanente's expanding financial footprint amplifies systemic risk. Its aggressive consolidation strategy accelerates corporate concentration in health care, shifting the sector toward a model where financial interest eclipses clinical responsibility. As profit outranks people, the broader health care ecosystem becomes less accountable and increasingly misaligned with its core mission. Ultimately, it's the patients who pay the price.

This growing risk we cannot afford to ignore. Addressing the urgent concerns raised by patients, caregivers, UNAC/UHCP, and the communities that rely on Kaiser is essential to protecting public health and the integrity of the nonprofit health care sector.

For years, Kaiser has shielded itself—and its growing empire—with carefully curated value statements and relatively modest community donations. But those gestures no longer conceal the widening chasm between its public narrative and its operational reality.

A growing chorus of voices—including patients, community members, and health care workers—is rising to replace the fiction with facts. Now it is time for action. This moment demands recognition and remedy. Because ultimately—even the most powerful of emperors must answer to the truth.

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A. HEALTH CARE WORKER AND PATIENT STATEMENTS

First-hand accounts submitted voluntarily via a publicly accessible digital portal created to gather lived experiences and elevate the voices of Kaiser Permanente patients and health care workers from October 2025 to December 2025 reveal a clear pattern of urgent concerns: patient safety, understaffing, delayed care, and worker burnout.

While most respondents were willing to share their city of residence publicly, a few chose to share their thoughts anonymously, out of fear of retaliation by Kaiser Permanente.

Source: Responses from Kaiser Permanente patients and health care workers to the question, "Why do you support nurses and health care professionals in their fight for safe staffing and fair contracts?"

A. HEALTH CARE WORKER AND PATIENT STATEMENTS

Patient Care

I broke my leg last year. I live on Maui, and there's only one hospital and it's Kaiser Permanente… In particular this hospital is really bad. Low quality Care. And they call security to kick you out after they treat you the quickest and the cheapest way they can. They've left sponges in people. They put a screw in my leg that came out. I had to have another hospital take it out.

Kaiser Permanente patient, Wailuku, HI

Kaiser management must come to [the] bedside and work as a staff nurse under the despicable conditions you have expected of them for just one week, and maybe you will change your tune. You have no idea what it is like to work under the conditions that you think are safe for patients or families. If one of the patients you are caring for are a part of your family, I am very sure you would change your attitude.

Kaiser Permanente patient, Woodland Hills, CA

The Administration of Kaiser Health Care should be held accountable for the polices [sic] that deny medical services for the patients who pay for their medical care. This lack of care is a dastardly example of profit over patient care!

Community member, Kapolei, HI

I currently work for Kaiser home health and have been a patient since I could remember. Kaiser makes it very well known that productivity is more of a concern than safe nurse staffing and patient safety. I have made staffing objections through the union, and management dodges any bullet to meet about them, stating concerns. I have reached out to management about concerns about the safety of patients being discharged home on home health such as septic, uncontrolled blood sugars, hypertensive crisis not controlled and ultimately I fight an uphill battle that ultimately doesn't go anywhere. It's exhausting, draining and makes our jobs feel impossible, risks our licenses, and puts patients at risk.

Kaiser Permanente patient and health care provider, Los Angeles

A. HEALTH CARE WORKER AND PATIENT STATEMENTS

Delays in Access to Care

When I was struggling with a severe mental health incident, it took 3 weeks to get care. That was unacceptable.

Kaiser Permanente patient, Castro Valley, CA

When I call to ask for an appointment to see a physician, the appointment is a month off. I am then told if I don't like it then go to Urgent Care. That is unacceptable! Kaiser's employees that I've met while at my appointments are the best and need to be treated better. If I have to wait a month for an appointment, that means Kaiser is understaffed. This problem needs to be remedied.

Kaiser Permanente patient, Gardena, CA

I'm tired of waiting to see a doctor, tired of the appointment center saying "go to URGENT CARE," why assign a doctor if you can't see your doc for months.

Kaiser Permanente patient and health care provider, Gardena, CA

I injured my rotator cuff and it took almost 2 months for me to get an appointment to see an orthopedic doctor and then another month to get an MRI done.

Kaiser Permanente patient, Murrieta, CA

I tried making an appointment to have a cyst evaluated on my face this morning. I was told there are no available appointments in the near future and was directed to urgent care. It's not okay that I cannot see my primary care physician until 3+ months out. This is not what I consider patient care. And I hope the powers will be at Kaiser, start to feel the same.

Kaiser Permanente patient, San Pedro, CA

A. HEALTH CARE WORKER AND PATIENT STATEMENTS

Delays in Access to Care (cont'd)

I have kidney disease & hypertension & require kidney ultrasounds and lab work regularly. In 2024 - it was a challenge to get a kidney scan; no answer in the appointment line. My Nephrologist herself had to MAKE THE PHONE CALL for the Ultrasound Dept to pick up and give me an appointment…after several days of attempts! This is not safe staffing and improvements need to be in place.

Kaiser Permanente patient and health care provider, Rancho Cucamonga

As a Kaiser nurse, due to Kaiser's short staffing, I have to endure patients yelling at me, frustrated about the lack of timely care. As a Kaiser patient, I struggle to get good care at Kaiser myself. I spend thousands of dollars outside of Kaiser to get the level of care, I know as a nurse, I deserve.

Kaiser Permanente patient and health care provider, Portland, OR

My daughter is trying to get a counseling appointment for something urgent. She is not in danger, so the next available appointment is 8 weeks out. I thought Kaiser got in trouble for this a few years back! Looks like we are back to their low staffing, no access model. Kaiser can do better!

Kaiser Permanente patient, Fairfield, Nor CA

Because corporate greed is rampant, Kaiser CEO makes $13-15 billion a year while we patients wait months for appointments and have to jump through unnecessary hoops to see a specialist or get the care we need.

Kaiser Permanente patient, Yucaipa, CA

Everyday I go to work, appointments keep getting further and further out. We got through Covid but yet scheduling is worse than before…It's heartbreaking to hear patients calling, crying that they are in pain and can't get in to get the surgery they need. Or that they are not feeling well and don't want to keep going to Urgent Care or ER. They just want to see their own PCP who is booked up for the next two months… The worse is, KP is all about preventative but a patient has to wait 4-6 months for a screening colonoscopy or be referred to an outside vendor. Why is it that outside vendors can see our patients faster than we can??

Kaiser Permanente health care provider, Tustin

A. HEALTH CARE WORKER AND PATIENT STATEMENTS

Understaffing

I've seen first hand as a patient how short staffing decreases the level of care, not because of the nurses, but because there's less resources.

Kaiser Permanente patient, San Diego

Patients should not be outsourced to non-KP providers for care just because KP doesn't want to higher [sic] more staff. Patients pay to be treated at KP not to be sent out.
We deserve respect and high quality care and we deserve to be compensated accordingly.

Kaiser Permanente health care provider, Downey, CA

Kaiser members expect top quality health care & they cannot provide that without safe staffing in every department!

Kaiser Permanente patient, Moreno Valley, CA

In late 2022 I try to access mental health evaluation for ADD. I was dealing with my husband going through chemotherapy and…having a really hard time. I had kept waiting for appointments to get various forms of evaluation, but after 3 months finally had an intake interview on the phone… afterward they sent me a questionnaire that would've made sense before that 90 minute evaluation, it just felt like they were running me along because there wasn't enough staff to deal with everybody…it would have been better if they had just outsourced me elsewhere because I really had a hard time and i'm doing better now but it's with no help from kaiser.

Kaiser Permanente patient, Alameda, CA

A. HEALTH CARE WORKER AND PATIENT STATEMENTS

Understaffing (cont'd)

Understaffing creates backlogs, holds up patient care. Thorough care, clean rooms, bedside assistance, imaging, all are affected as well as poor outcomes for patients who don't have enough eyes on them.

Patient satisfaction is low, trust is broken both in patients and in staff morale. We could do so much more for the patients with well run hospital systems and departments.

Kaiser is more worried about landscaping and acquisitions. Money is going to these instead of patient care and employee support. Linen services were changed to save money, Now we get ripped and threadbare sheets and blankets for the patients. Equipment is antiquated to care for patients. The administration is top heavy and the support staff are meager, yet this is what is holding them up. The haves and the have nots.

Kaiser Permanente health care professional, Solano County, CA

I am a Kaiser nurse and a Kaiser patient. I have seen first hand what short staffing does to both employees and its members. Members are constantly forced to walk in to our busy Urgent care because there is no access to primary care. Kaiser can do better, they are choosing not to.

Kaiser Permanente patient and health care provider, Corona, CA

My daughter was hospitalized over 6 times in the past 2 years. During this time the nursing staff was pushed to the limit. It was concerning that many times, my daughter was not attended to as often as she needed. It was up to us to fill in.

Kaiser Permanente patient, Stevenson Ranch, CA

A. HEALTH CARE WORKER AND PATIENT STATEMENTS

Understaffing (cont'd)

My daughter provides excellent empathic care as a Physical Therapist with Kaiser. She sees patients who are suffering because there are not enough caregivers, specifically Physical Therapists, to treat people in a timely way. This breaks her heart!

Community member, Prescott Valley, CA

The nurses are totally burnt out because there just aren't enough of them. And guess who gets stuck waiting forever? We do. We're basically paying for the short-staffing with our own time sitting in the waiting room.

Kaiser Permanente patient, Sherman Oaks, CA

I'm a Kaiser patient and so is my family. If my family member were admitted, I would want him/her to have the care and attention needed to get well. I don't want the place where my family gets care to be run by transitional nurses who come and go because Kaiser can't retain staff. I want caregivers who know what they are doing, care about what they are doing and have the bandwidth to provide quality care. Burned out, over worked nurses cannot provide safe care.

Kaiser Permanente patient, Torrance

A. HEALTH CARE WORKER AND PATIENT STATEMENTS

Worker Burnout

I have been affected on both ends, as a Kaiser member and a nurse.

The delay in care has affected my wellbeing. I am no longer the same nurse I once was. I smiled often at work and patients and staff knew me as the one who always smiled. Now the patients remind me to smile, but its hard to force a smile when you are forced to run around and work tirelessly… I feel guilty even going on break because my patients always need something…

My health has declined significantly this year. I was admitted to the hospital due to stress and GI issues which I never had prior. All this came about because of work stress and targeted harassment.

Now as a patient. It took them close to 4 months to finally complete the diagnostic test I needed to rule out serious issues.

I just did my test last Friday but I was hospitalized in April this year. That's how much time it took the GI department to schedule me…

I am not able to work like I used to so this is affecting how I deliver care and how I am treated at work…Yet Kaiser won't pay us fairly and provide better staffing…I don't know how much longer I can take this.

Kaiser Permanente patient and health care provider, Yucaipa, CA

Appendix A.
HEALTH CARE WORKER AND PATIENT

Worker Burnout (cont'd)

My unit has been so chronically understaffed that after working a brutal shift this week, I had to cancel my own doctors appointment at Kaiser the next morning because I was so exhausted… And this was an appointment that I waited months for. Until Kaiser staffs up and takes care of us we won't have the energy to take care of ourselves.

Kaiser Permanente patient and health care provider, San Diego

I work for Kaiser Permanente as a service representative and I watch these nurses day in and day out working shift after shift away from their families to care for everybody else's families. And they do it with grace, respect, and they do it with the utmost care and love everyday. They deserve to have a break, they deserve to have time with their family, they deserve to be seen and heard and respected. I shouldn't see the same nurses on the floor when I clock out and when I clock back in. I shouldn't see a nurse clock out at noon and back by 4:00 because they're short- staffed. Something has got to give, and the nurses have been giving all that they have, so now it's time for Kaiser to be that something that has to give.

Kaiser Permanente employee, Apple Valley, CA,

Appendix B.
Proper Staffing Creates the Conditions for Clinical Excellence

Imagine health care at its best. It begins with proper staffing. Every shift, there are enough skilled professionals with the right mix of skills and experience to handle the patient load and acuity. With adequate staffing, caregivers have the time to build genuine relationships with patients. They have time to listen, thoroughly explain, detect changes early, and respond with calm competence. Patients notice this immediately. They feel valued, connected, and genuinely cared for. In this environment, patients can see and feel the value of the premiums they pay. They appreciate the timely care, clear communication, and most importantly, safe outcomes. Patients benefit from a health care experience built on trust and dignity.

Employers and purchasers benefit as well because the premium dollars they invest translate into real access, real quality, and real outcomes. Clinicians experience this too. They experience pride and feel respected, supported, and trusted to practice at the top of their training, with the capacity to think critically, solve complex problems, and prevent crises. Care teams consistently follow best practices, care plans are coordinated, safety protocols are adhered to, and education is provided, all resulting in overall clinical excellence.

Now imagine health care at its worst. Chronic understaffing turns care into a constant crisis. Patients face prolonged wait times, basic needs go unmet, call lights go unanswered, and communication becomes rushed or fragmented. Not because staff don't care, but because there simply aren't enough hands or hours.

Patients experience the emotional toll of feeling invisible, anxious, and uncertain, as if they are being processed rather than cared for. When that happens, they understandably question what they are paying for. Premiums are faithfully paid, yet the care experience feels delayed, diminished, and transactional, eroding confidence that the system delivers the promised value. Clinicians also bear the burden. They are forced into impossible choices, cutting corners to get through the shift, leaving work with moral distress, exhaustion, and fear that something was missed. Under these conditions, best practices break down, coordination suffers, errors increase, and the whole care experience becomes less safe, less humane, and less reliable.

UNAC/UHCP's Commitment and Role in Ensuring Quality of Care

Unions play a vital—often decisive—role in ensuring safe staffing. They empower frontline clinicians to turn professional standards that improve patient care and promote clinical excellence into enforceable workplace commitments through collective bargaining. Unlike corporate "staffing plans" or scheduling templates that can change with budgets or leadership priorities, unions guarantee that care standards are maintained despite changing circumstances. This understanding is central to everything UNAC/UHCP members bring to the bargaining table. During negotiations, UNAC/UHCP nurses and health care professionals chronic understaffing, and ensure an appropriate skill mix to meet complex patient needs.

Employers and purchasers benefit as well because the premium dollars they invest translate into real access, real quality, and real outcomes. Clinicians experience this too. They experience pride and feel respected, supported, and trusted to practice at the top of their training, with the capacity to think critically, solve complex problems, and prevent crises. Care teams consistently follow best practices, care plans are coordinated, safety protocols are adhered to, and education is provided, all resulting in overall clinical excellence.

Staffing Objections: A System for Patient Safety and Accountability

UNAC/UHCP helped develop and formalize a staffing objection system at Kaiser to accomplish two goals. First, the system quickly alerts unit managers when staffing levels, workload, or acuity create unsafe conditions, giving Kaiser management the opportunity and responsibility to intervene while the risk remains. Second, it establishes accountability. Each objection generates a documented record that prevents ongoing staffing failures from being dismissed as "isolated incidents" and allows patterns to be tracked across units and facilities. In this way, staffing objections serve as both an urgent safety notification system and a union-driven accountability tool, designed to expose systemic problems and compel lasting operational changes that protect patients and support clinical excellence.

A two-year snapshot (Nov 2023–Nov 2025) shows that UNAC/UHCP caregivers filed 13,807 staffing objections in Southern California Kaiser facilities—about 19 documented alerts per day on average. Staffing objections are not casual complaints or "venting" after a hard shift. They are formal, real-time safety reports filed by frontline clinicians when staffing levels, workload, or patient acuity create conditions where safe care is at risk. Importantly, 13,807 is not a complete picture of the problem.

In a chronically understaffed system, caregivers can become frustrated and demoralized and some eventually stop filing because they feel nothing changes, the process takes time they don't have, or unsafe conditions have become normalized. Even so, those 13,807 objections represent 13,807 documented warnings that patient care was at heightened risk under unsafe conditions - warnings issued at Kaiser Permanente facilities by the very professionals responsible for protecting patients in the moment.

Patient-safety research describes what happens when tasks accumulate faster than clinicians can safely complete them: missed nursing care—care that is delayed, partially completed, or not completed at all. This is how systems "fail quietly":

- assessments happen late
- medications drift off schedule
- discharge teaching becomes a rushed handoff
- subtle deterioration is recognized later than it should be

Understaffing often doesn't produce dramatic, headline errors. More commonly, it produces predictable delays that impact quality of care and steadily increase risk.

Staffing isn't optional: it's an obligation

This debate is often framed as "preferences vs. cost." The floor is clearer than that. Adequate staffing is a legal requirement.

- **Federal requirement (Medicare Conditions of Participation):** hospitals must provide adequate nursing services to meet patient needs, including RN availability as needed.
- **California requirement (enforceable minimum ratios):** state law sets minimum nurse-to-patient ratios by unit and makes clear they are minimums, not targets. Hospitals must also adjust staffing based on acuity using a documented patient-classification system when patient needs require more care.

- **Kaiser's additional requirement (negotiated minimums):** Kaiser also operates under collective bargaining staffing standards that can be more protective than legal minimums. Both sets apply: law is enforceable through regulators; contract standards are enforceable through grievance/arbitration and related legal pathways.

This is an issue of accountability and Kaiser's, "We don't want to talk about reserves" approach does not erase staffing commitments already on the books. If obligations are consistently met, Kaiser should be able to demonstrate that shift by shift, not "on average." If they are not met, the consequences don't vanish—they shift onto patients (delays, compromised or missed care) and onto caregivers (overload, moral injury).

While there is no single rule that says, "reserves must be spent on staffing," the governing principle is this: **Reserves and investment surpluses demonstrate capacity.** If an organization has substantial reserves but refuses to discuss using that capacity to stabilize staffing during chronic shortfalls, then understaffing is no longer an unavoidable constraint. It becomes a choice—one with foreseeable patient-care consequences.

That is why Kaiser's $66 billion in reserves belong in the staffing conversation:

- Staffing is a legal and operational requirement, not a discretionary "nice to have."
- Chronic understaffing produces measurable access delays, compromised or missed care—not just employee dissatisfaction.
- In a nonprofit system, reserves reflect mission capacity: what the institution can sustain to meet community obligations, not simply what it prefers to spend.

Nonprofit disclosures and audited financials make it reasonable to ask: when documented, recurring staffing alerts point to ongoing risk, how is available capacity being used to meet basic care obligations?

- **Capital projects and modernization:** New hospitals, upgrades, and expansion.
- **Bond covenants, credit ratings, and cost of borrowing:** Maintaining strong reserves can protect credit ratings and reduce borrowing costs.
- **Regulatory and insurance-like requirements:** Integrated systems often hold funds for claims risk, risk-based capital, and contingency planning.

- **Operating volatility and disaster readiness: Reserves buffer shocks:** pandemics, wildfires, cyberattacks, supply chain disruptions, sudden staffing market shifts.
- **Pension/retiree obligations and long-term liabilities:** Long-horizon commitments require financial stability.

Those are plausible reasons to hold $66 billion in reserves. But they do not answer the central question: **What is the purpose of financial strength if not to prevent predictable, ongoing harm when the harm is already documented?**

Here's the comparison that matters: Holding surpluses for a future facility project, a future market shock, or future strategic flexibility may be prudent. But a documented patient-safety risk unfolding now—with daily staffing objections—is exactly the kind of mission-critical problem reserves exist to absorb.

Reserves are not only for earthquakes and recessions. They're also for preventing a health system from running in a permanent state of unsafe delay—especially when the organization has public, enforceable obligations to staff adequately.

There is also a business reality: chronic understaffing has real costs that often exceed the cost of stabilization—overtime pay spirals, turnover, vacancy premiums, reliance on travelers/agency at higher pay rates, increased length of patient stay from delays, avoidable medical complications, higher liability exposure, staff injuries, and reputational damage. Using a portion of reserves as time-limited bridge funding to stabilize staffing can be fiscally conservative compared to paying indefinitely for crisis staffing.

The human cost: Moral injury is the predictable outcome of chronic staffing issues

Moral injury occurs when clinicians are forced into conditions that violate their professional values: they know what patients need, but the system makes reliable care impossible. In chronically understaffed settings, that becomes constant

- which call light waits
- which teaching gets shortened
- which reassessment is deferred

Over time, moral injury fuels burnout, turnover, and instability—making staffing worse and delays deeper. Staffing objections don't just document inconvenience; they map conditions associated with patient risk today and workforce erosion tomorrow.

What accountability looks like

If Kaiser is meeting legal and negotiated standards, accountability should be straightforward. If it is not, the costs are being shifted onto:

- **patients** through risky delays and missed care,
- **caregivers** through overload, burnout, and moral injury.

A practical remedy is equally straightforward:

1. **Meet legally mandated and negotiated staffing minimums every shift** (not just "on average").
2. **Treat staffing objections as real-time safety alerts** with documented mitigation, escalation, and follow-through.
3. **Use objection patterns to identify chronic hotspots** and enforce accountability where shortfalls recur.
4. **Include reserves and financial capacity in stabilization planning—**not as a blank check, but as mission-aligned bridge funding to fix recurring patient-safety risk now (e.g., targeted retention, float pool expansion, rapid hiring/training supports, acuity-based staffing reinforcement, and reducing reliance on costly emergency measures).

Refusing to discuss stabilization tools is not neutrality. It is a high-risk and ethically fraught decision—one with severe consequences to access, safety, and retention. In a nonprofit system with substantial capacity, reserves don't end the staffing conversation. They shape it.

Appendix C.
A Smart Parasite Keeps Its Host Alive

By Garie Connell
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A Kaiser Permanente physician recently apologized for calling striking nurses and staff “parasites” and alluded that they were so dumb in demanding safe staffing they would kill their own host. He had meant to send the message to a small group, but accidentally texted it to the very nurses he was describing. A Freudian typo, perhaps – the kind that tells the truth before the conscious mind has a chance to edit.

In his follow-up email, he expressed regret for the analogy, insisting it didn’t reflect his views. But that’s precisely what makes this moment worth examining. Because whether he knew it or not, the “parasite” metaphor captures the unconscious life of the American healthcare system – and the sickness that’s taken root within it.

The Parasite and the Host

In nature, a smart parasite doesn’t kill its host. It adapts, hides in plain sight, and convinces the host that its survival depends on the parasite’s continued presence. That is the role the C-suite and insurance companies play in modern healthcare.

They feed off the vitality of clinicians and patients while claiming to be the system’s lifeblood. They’ve evolved exquisite forms of camouflage: “care innovation” slogans, physician or nurse administrators, and cheerful wellness campaigns – all very people who make care possible. Their language is the linguistic equivalent of a tick’s anesthetic: soothing, numbing, and designed to keep the host still.

By contrast, the nurses, therapists, and staff who strike or unionize are not parasites at all. They are the immune system. When they withhold labor, it’s not to harm the organism – it’s to provoke a fever, a necessary inflammation that signals the body is trying to heal.

The Real Organism

Kaiser Permanente began as an experiment in collective health – a system designed to integrate care and promote wellness. But like many American institutions (and this ER doctor), it has been gradually reprogrammed by market logic. Its nervous system now fires in response to profit signals rather than ethical ones.

What was once a model of industrial medicine has become an empire of managed scarcity: too few clinicians, too little time, too many metrics masquerading as care. The organization behaves like a private-equity firm, one that views labor not as a partnership but as overhead.

Each time workers organize or strike, leadership treats it as an autoimmune flare – something to suppress rather than understand. Public relations memos and "sincere apologies" become the antibiotics of control, attempting to calm the body while the deeper infection festers.

The Psychodynamics of Institutional Denial

As a clinical social worker, I see in this dynamic the same defenses that operate in human relationships: splitting, projection, and denial. The institution divides itself into two selves – the "noble mission" and the "problematic workforce." It then projects its own dependency and greed onto the staff, accusing them of wanting too much while the executives quietly extract their own nourishment through bonuses and administrative bloat.

In psychoanalytic terms, this phenomenon is known as projective identification. In political terms, it's called union-busting.

The doctor's apology reveals the unconscious of the system he has privileged and believes serves him. It's not just one person's misstep – it's a linguistic eruption from a culture that has forgotten who the host really is.

The True Host

The real host isn't Kaiser corporate, and it isn't the insurance industry. The real host is the public – the patients, the clinicians, the communities who rely on care and provide it.

When those who profit from the system mistake themselves for the host, they justify anything that keeps them fed: delays in treatment, impossible caseloads, algorithmic decision-making, and the erosion of therapeutic relationships.

They call it efficiency (or intelligence), I call it parasitism.

A Modest Proposal for the Parasite

If the executives and insurers insist on being the "smart parasite," then perhaps they should act like one: keep the host alive. Feed it, rather than bleed it dry, as the doctor suggests.

That means paying staff fairly, respecting union contracts, and allowing time for care that is actually humane. It means listening to the clinicians who understand suffering not as a metric, but as a reality.

Because here's what the doctor should know about human hosts: we develop resistance. We unionize. We tell stories. We remember who keeps the organism alive.

A smart parasite keeps its host alive.

A wise one learns to become symbiotic – or steps aside and lets the body heal, right, Doctor?

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Appendix D.
RACE DISCRIMINATION LAWSUITS

By its own telling, Kaiser casts itself as a vanguard of equity and inclusion. Yet this has become increasingly difficult to reconcile with a record of lawsuits, settlements, and unresolved allegations of systemic racial discrimination and retaliation.

In 2021, the organization paid $18.9 million to settle two class-action lawsuits representing roughly 4,500 African American and Latino employees who alleged they were paid less and denied advancement opportunities compared with non-Black and non-Latino peers performing substantially similar work—claims Kaiser denied, yet chose to resolve through substantial financial settlements, according to the Workplace Rights Law Group.

These cases were preceded by internal warnings from a diversity and inclusion employee who alleged that Latino workers were being underpaid by tens of thousands of dollars and who, after raising the issue to senior leadership, was placed on administrative leave, and is no longer employed by Kaiser, according to the Sampath Law Firm.

PROFITS OVER PATIENTS:

Kaiser Permanente's Shift in Institutional Priorities and the Dire Consequences to Health Care