KAISER FOUNDATION HEALTH PLAN, INC. AND SUBSIDIARIES AND KAISER FOUNDATION HOSPITALS AND SUBSIDIARIES

Combined Financial Statements

December 31, 2016 and 2015

(With Independent Auditors' Report Thereon)

KAISER FOUNDATION HEALTH PLAN, INC. AND SUBSIDIARIES AND KAISER FOUNDATION HOSPITALS AND SUBSIDIARIES

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KPMG LLP
Suite 1400
55 Second Street
San Francisco, CA 94105

Independent Auditors' Report

The Boards of Directors
Kaiser Foundation Health Plan, Inc.
and Kaiser Foundation Hospitals:

We have audited the accompanying combined financial statements of Kaiser Foundation Health Plan, Inc. and Subsidiaries (Health Plans) and Kaiser Foundation Hospitals and Subsidiaries (Hospitals), which comprise the combined balance sheets as of December 31, 2016 and 2015, and the related combined statements of operations and changes in net worth, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the combined financial position of Health Plans and Hospitals as of December 31, 2016 and 2015, and the results of their operations and their cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

KPMG LLP

San Francisco, California
February 14, 2017

KAISER FOUNDATION HEALTH PLAN, INC. AND SUBSIDIARIES AND KAISER FOUNDATION HOSPITALS AND SUBSIDIARIES

Combined Balance Sheets

December 31, 2016 and 2015

(In millions)

Assets	2016	2015
Current assets:		
Cash and cash equivalents	$ 434	$ 210
Current investments	8,677	6,554
Securities lending collateral	631	1,068
Broker receivables	767	816
Due from associated medical groups	12	5
Accounts receivable - net	2,030	1,966
Inventories and other current assets	1,357	1,422
Total current assets	13,908	12,041
Noncurrent investments	25,756	26,189
Land, buildings, equipment, and software - net	24,342	23,782
Other long-term assets	607	585
Total assets	$ 64,613	$ 62,597
Liabilities and Net Worth		
Current liabilities:		
Accounts payable and accrued expenses	$ 3,852	$ 2,977
Medical claims payable	1,862	1,750
Due to associated medical groups	862	784
Payroll and related charges	1,828	1,694
Securities lending payable	631	1,068
Broker payables	849	1,160
Long-term debt subject to short-term remarketing arrangements - net	785	732
Other current debt	1,904	775
Other current liabilities	2,102	2,027
Total current liabilities	14,675	12,967
Long-term debt	4,754	6,060
Physicians' retirement plan liability	6,566	5,730
Pension and other retirement liabilities	9,148	10,525
Other long-term liabilities	2,380	2,418
Total liabilities	37,523	37,700
Net worth	27,090	24,897
Total liabilities and net worth	$ 64,613	$ 62,597

See accompanying notes to combined financial statements.

KAISER FOUNDATION HEALTH PLAN, INC. AND SUBSIDIARIES AND KAISER FOUNDATION HOSPITALS AND SUBSIDIARIES

Combined Statements of Operations and Changes in Net Worth

Years ended December 31, 2016 and 2015

(In millions)

	2016	2015
Revenues:		
Members' dues	$ 43,315	$ 40,956
Medicare	15,414	14,436
Copays, deductibles, fees, and other	5,822	5,357
Total operating revenues	64,551	60,749
Expenses:		
Medical services	30,486	27,732
Hospital services	16,664	16,364
Outpatient pharmacy and optical services	7,370	7,059
Other benefit costs	4,099	3,900
Total medical and hospital services	58,619	55,055
Health Plan administration	4,008	3,928
Total operating expenses	62,627	58,983
Operating income	1,924	1,766
Other income and expense:		
Investment income - net	1,379	300
Interest expense	(183)	(198)
Total other income and expense	1,196	102
Net income	3,120	1,868
Change in pension and other retirement liability charges	(1,215)	2,997
Change in net unrealized gains on investments	299	(793)
Change in restricted donations	(1)	(2)
Change in noncontrolling interest	(10)	—
Change in net worth	2,193	4,070
Net worth at beginning of year	24,897	20,827
Net worth at end of year	$ 27,090	$ 24,897

See accompanying notes to combined financial statements.

KAISER FOUNDATION HEALTH PLAN, INC. AND SUBSIDIARIES AND KAISER FOUNDATION HOSPITALS AND SUBSIDIARIES

Combined Statements of Cash Flows

Years ended December 31, 2016 and 2015

(In millions)

	2016	2015
Cash flows from operating activities:		
Net income	$ 3,120	$ 1,868
Adjustments to reconcile net income to net cash provided from operating activities:		
Depreciation and software amortization	2,299	2,158
Other amortization	(76)	(6)
Loss (gain) recognized on investments - net	(752)	175
Loss on land, buildings, equipment, and software - net	31	60
Changes in assets and liabilities:		
Accounts receivable - net	(64)	(125)
Due from associated medical groups	(7)	(5)
Other assets	83	(211)
Accounts payable and accrued expenses	814	11
Medical claims payable	112	357
Due to associated medical groups	(9)	(204)
Payroll and related charges	134	(138)
Pension and other retirement liabilities	(2,233)	(959)
Other liabilities	(10)	338
Net cash provided from operating activities	3,442	3,319
Cash flows from investing activities:		
Additions to land, buildings, equipment, and software	(2,786)	(2,698)
Proceeds from sales of land, buildings, and equipment	5	5
Proceeds from investments	37,699	38,930
Investment purchases	(38,278)	(40,169)
Decrease in securities lending collateral	437	460
Broker receivables / payables	(262)	20
Issuance of notes receivable	(170)	(161)
Prepayment and repayment of notes receivable	107	144
Other investing	24	28
Physicians' retirement plan liability	491	524
Net cash used in investing activities	(2,733)	(2,917)
Cash flows from financing activities:		
Issuance of debt	3,261	1,454
Prepayment and repayment of debt	(3,298)	(1,472)
Decrease in securities lending payable	(437)	(460)
Change in restricted donations	(1)	(2)
Change in noncontrolling interest	(10)	—
Net cash used in financing activities	(485)	(480)
Net change in cash and cash equivalents	224	(78)
Cash and cash equivalents at beginning of year	210	288
Cash and cash equivalents at end of year	$ 434	$ 210
Supplemental cash flows disclosure:		
Cash paid for interest - net of capitalized amounts	$ 214	$ 212
Noncash changes in accounts payable related to purchases of fixed assets	$ 61	$ —

See accompanying notes to combined financial statements.

(1) Description of Business

The accompanying combined financial statements include Kaiser Foundation Health Plan, Inc. and Subsidiaries (Health Plans) and Kaiser Foundation Hospitals and Subsidiaries (Hospitals). Health Plans and Hospitals are primarily not-for-profit corporations whose capital is available for charitable, educational, research, and related purposes. Health Plans are primarily health maintenance organizations and are generally exempt from federal and state income taxes. Membership at December 31, 2016 and 2015 was 10.7 million and 10.2 million, respectively. At December 31, 2016 and 2015, the percentage of enrolled membership in California was approximately 77% and 78%, respectively. The principal operating subsidiary of Kaiser Foundation Hospitals is Kaiser Hospital Asset Management, Inc. (KHAM). The principal operating subsidiaries of Kaiser Foundation Health Plan, Inc. (Health Plan, Inc.) are:

Kaiser Foundation Health Plan of Colorado
Kaiser Foundation Health Plan of Georgia, Inc.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Kaiser Foundation Health Plan of the Northwest
Kaiser Health Plan Asset Management, Inc. (KHPAM)

Independent Medical Groups (Medical Groups) cooperate with Health Plans and Hospitals in conducting the Kaiser Permanente Medical Care Program. Health Plans contracts with Hospitals and the Medical Groups to provide or arrange hospital and medical services for members. Hospitals also contracts with the Medical Groups for certain professional services. Contract payments to the Medical Groups represent a substantial portion of the expenses for medical services reported in these combined financial statements. Payments from Health Plans and Hospitals constitute substantially all of the revenues for the Medical Groups. Because the Medical Groups are independent and not controlled by Health Plans and Hospitals, their financial statements are not combined or consolidated with Health Plans and Hospitals.

At December 31, 2016 and 2015, the percentage of Health Plans' and Hospitals' total labor force covered under collective bargaining agreements was approximately 71% and 70%, respectively. At December 31, 2016, approximately 10% of the workforce was covered under collective bargaining agreements that were scheduled to expire within one year. At December 31, 2016, none of the workforce was working under an expired agreement, and approximately 1% of the workforce was in a new bargaining unit that was negotiating an agreement.

Health Plans and Hospitals strive to improve the health and welfare of the communities they serve through their Community Benefit investment programs. Community Benefit expenditures provide funding for programs that serve communities through research, community-based health partnerships, the provision of charity care to low-income patients, direct health coverage for low-income families, and collaboration with community clinics, health departments, and public hospitals.

Cost-based methods are used to account for losses incurred under the care and coverage lines of business qualifying for treatment as Community Benefit. Patients assigned to these lines of business must first prove eligibility based upon family income relative to the Federal Poverty Guidelines. Most costs determined to be

Community Benefit are allocated across the lines of business following pre-determined allocation rules applied within the organization's cost accounting systems. Certain Community Benefit costs are determined using the out-of-pocket costs directly billed to patients or a cost-to-charge ratio applied to uncompensated charges associated with care provided to these patients.

For the year ended December 31, 2016, Community Benefit expenditures (at cost, net of approximately $3.0 billion of related revenues) were $2.5 billion, representing 3.9% of operating revenue. In comparison, for the year ended December 31, 2015, Community Benefit expenditures (at cost, net of $2.6 billion of related revenues) were $2.1 billion, representing 3.5% of operating revenue.

(2) Summary of Significant Accounting Policies

(a) Basis of Presentation

The financial statements of Health Plans and Hospitals are presented on a combined basis due to the operational interdependence of these organizations and because their governing boards and management are substantially the same. These combined financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America (GAAP). All material intercompany balances and transactions have been eliminated. Management has evaluated subsequent events through February 14, 2017, which is the date that these combined financial statements were issued.

(b) Cash and Cash Equivalents

Cash and cash equivalents include interest-bearing deposits purchased with an original or remaining maturity of three months or less. Cash and investments that are restricted per contractual or regulatory requirements are classified as noncurrent investments and excluded from cash and cash equivalents.

(c) Investments

Investments include equity, U.S. Treasury, government agencies, money market funds, and other marketable debt securities and are reported at fair value. Investments are categorized as current assets if they are intended to be available to satisfy current liabilities. Alternative investments are reported under the equity method. Certain investments are illiquid and are valued based on the most current information available. Other-than-temporary impairment and recognized gains and losses, which are recorded on the specific identification basis, and interest, dividend income, and income from equity method alternative investments are included in investment income - net. Health Plans and Hospitals have designated a portion of their investments for the physicians' retirement plan liability related to defined retirement benefits provided for physicians associated with certain Medical Groups. These investments are unrestricted assets of Health Plans and Hospitals. A portion of investment income that represents the expected return on the investments designated for the physicians' retirement plan has been recorded as a reduction in the provision for physicians' retirement plan benefits and is excluded from investment income - net, as described in the *Physicians' Retirement Plan* note.

Investments are regularly reviewed for impairment and a charge is recognized when the fair value is below cost basis and is judged to be other-than-temporary. In its review of assets for impairment that is deemed other-than-temporary, management generally follows the following guidelines:

- Substantially all investments are managed by outside investment managers who do not need Health Plans' or Hospitals' management preapproval for sales; therefore, substantially all declines in value below cost are recognized as impairment that is other-than-temporary.
- For other securities, losses are recognized for known matters, such as bankruptcies, regardless of ownership period, and investments that have been continuously below book value for an extended period of time are evaluated for impairment that is other-than-temporary.

All other unrealized losses and all unrealized gains on investments are included as other changes in net worth.

Interest income is calculated under the effective interest method and included in investment income - net. Dividends are included in investment income - net on the ex-dividend date, which immediately follows the record date.

Health Plans' and Hospitals' investment transactions are recorded on a trade date basis.

(d) Securities Lending Collateral and Payable

Health Plans and Hospitals enter into securities lending agreements whereby certain securities from their portfolios are loaned to other institutions. Securities lent under such agreements remain in the portfolios of Health Plans and Hospitals. Health Plans and Hospitals receive a fee from the borrower under these agreements, which is recognized ratably over the period that the securities are lent. Collateral, primarily cash, is required at a rate of 102% of the fair value of securities lent and is carried as securities lending collateral. The obligation of Health Plans and Hospitals to return the cash collateral is carried as securities lending payable. The fair value of securities lending collateral is determined using level 1 or 2 inputs as appropriate, as defined in the *Fair Value Estimates* note. The fair value of the loaned securities is monitored on a daily basis, with additional collateral obtained or refunded as the fair value of the loaned securities fluctuates.

(e) Broker Receivables and Payables

Broker receivables and payables represent current amounts for unsettled securities sales or purchases.

(f) Inventory

Inventories, consisting primarily of pharmaceuticals and supplies, are carried at the lower of cost (generally first-in, first-out or average price) or market.

(g) Land, Buildings, Equipment, and Software

Land, buildings, equipment, and software are stated at cost less accumulated depreciation and amortization. Interest is capitalized on facilities construction and internally developed software work in progress and is added to the cost of the underlying asset. Software, which includes internal and external costs incurred in developing or obtaining computer software for internal use, is capitalized. Qualifying costs incurred during the application development stage are capitalized. Depreciation and amortization begin when the project is substantially complete and ready for its intended use. Software is amortized on a straight-line basis over the estimated useful lives, generally ranging from 3 to 7 years. Buildings and equipment are depreciated on a straight-line basis over the estimated useful lives of the various classes of assets, generally ranging from 3 to 34 years.

Management evaluates alternatives for delivering services that may affect the current and future utilization of existing and planned assets and could result in an adjustment to the carrying values or remaining lives of such land, buildings, equipment, and software in the future. Management evaluates and records impairment losses or adjusts remaining lives, where applicable, based on expected utilization, projected cash flows, and recoverable values.

Maintenance and repairs are expensed as incurred. Major improvements that increase the estimated useful life of an asset are capitalized. Upon the sale or retirement of assets, recorded cost and related accumulated depreciation are removed from the accounts, and any gain or loss on disposal is reflected in operations.

Management estimates the fair value of asset retirement obligations that are conditional on a future event if the amount can be reasonably estimated. Estimates are developed through the identification of applicable legal requirements, identification of specific conditions requiring incremental cost at time of asset disposal, estimation of costs to remediate conditions, and estimation of remaining useful lives or date of asset disposal.

(h) Medical Claims Payable

The cost of health care services is recognized in the period in which services are incurred. Medical claims payable consists of unpaid health care expenses to third party providers, which include an estimate of the cost of services provided to Health Plans' members by the third party providers that have been incurred but not reported. The estimate for incurred but not reported claims is based on actuarial projections of costs using historical paid claims and other relevant data. Estimates are monitored and reviewed and, as claim payments are received, adjudicated, and paid, estimates are revised and are reflected in current operations. Such estimates are subject to actual utilization of medical services, changes in membership and product mix, claim submission and processing patterns, medical inflation, and other relevant factors. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. While the ultimate amount of paid claims is dependent on future developments, management is of the opinion that the reserves for claims are adequate to cover such claims.

Health Plans and Hospitals record anticipated reinsurance recoveries for high cost claims eligible for reimbursement under the Patient Protection and Affordable Care Act (PPACA) as described in *The PPACA Health Insurance Providers Fee, Reinsurance, Risk Adjustment, and Risk Corridors Programs* note. The amount recorded is an estimate as the ultimate adjudication of these claims is conducted by the government.

(i) Due to Associated Medical Groups

Due to associated medical groups consists primarily of unpaid medical expenses owed to the Medical Groups for medical services provided to members under medical services agreements with Health Plans. The cost of medical services is recognized by Health Plans in the period in which services are provided and is reflected as a component of medical and hospital services expenses.

(j) Self-Insured Risks

Costs associated with self-insured risks, primarily for professional, general, and workers' compensation liabilities, are charged to operations based upon actual and estimated claims. The portion estimated to be paid during the next year is included in current liabilities. The estimate for incurred but not reported self-insured claims is based on actuarial projections of costs using historical claims and other relevant data. Estimates are monitored and reviewed and, as settlements are made or estimates are revised, adjustments are reflected in current operations. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. While the ultimate payments for self-insured claims are dependent on future developments, management is of the opinion that the reserve for self-insured risks is adequate. Insurance coverage, in excess of the per occurrence self-insured retention, has been secured with insurers or reinsurers for specified amounts for professional, general, and workers' compensation liabilities. Decisions relating to the limit and scope of the self-insured layer and the amounts of excess insurance purchased are reviewed each year, subject to management's analysis of actuarial loss projections and the price and availability of acceptable commercial insurance.

(k) Premium Deficiency Reserves

Premium deficiency reserves and the related expense are recognized when it is probable that expected future health care and maintenance costs under a group of existing contracts will exceed anticipated future premiums and reinsurance recoveries over the contract period. If applicable, premium deficiency reserves extending beyond one year are shown as a long-term liability. Expected investment income and interest expense are included in the calculation of premium deficiency reserves, as appropriate. The level at which contracts are grouped for evaluation purposes is generally by geographic region. The methods for making such estimates and for establishing the resulting reserves are reviewed and updated, and any resulting adjustments are reflected in current operations. At December 31, 2016 and 2015, premium deficiency reserves were $16 million and $45 million, respectively. Given the inherent variability of such estimates, the actual liability could differ significantly from the calculated amount.

(l) Derivative Financial Instruments

Derivative financial instruments are utilized primarily to manage the interest costs and the risk associated with changing interest rates. Health Plans and Hospitals enter into interest rate swaps with investment or commercial banks with significant experience with such instruments. In addition, certain investments include derivative products. The changes in the fair value of these derivative instruments are included in investment income - net and settlement costs are recorded as interest expense or investment income - net.

Derivative financial instruments are also utilized to manage the risk of holding equity investments, primarily to hedge downside volatility risk. Heath Plans and Hospitals enter into derivatives such as put-spread collars with similar investment or commercial banks noted above. The changes in fair value for these derivatives are included in investment income - net.

Derivative financial instruments are utilized by Health Plans' and Hospitals' investment portfolio managers. These instruments include futures, forwards, options, and swaps. The changes in fair value for these derivative financial instruments are included in investment income - net.

(m) Revenue Recognition

Members' dues revenue includes premiums from employer groups and individuals. Members' dues revenue is recognized over the period in which the members are entitled to health care services.

Health Plans estimates accrued retrospective premium adjustments for certain group health insurance contracts based on claims experience and the provisions of the contract. Health Plans records accrued retrospective premiums as an adjustment to members' dues. For the years ended December 31, 2016 and 2015, the amount of premiums written by Health Plans subject to the retrospective rating feature were $932 million and $786 million, respectively. During the years ended December 31, 2016 and 2015, revenue derived under these contracts was 2.1% and 1.9%, respectively, of total members' dues. During the years ended December 31, 2016 and 2015, retrospective dues reductions derived under these contracts were $21 million and $15 million, respectively.

Health Plans participate in certain contracts with commercial large groups that include provision for risk adjustment of dues premiums, based on comparative data provided by Health Plans as well as other health plan vendors participating in these same arrangements. Settlements are typically calculated and paid according to the contract provisions and final settlements are made after the contract terms expire. For the years ended December 31, 2016 and 2015, dues subject to these risk adjustment arrangements comprise 8.8% and 8.5%, respectively, of total members' dues. For the years ended December 31, 2016 and 2015, $42 million and $87 million, respectively, have been recorded as reductions to revenue for these risk adjustment arrangements.

The majority of Health Plans' and Hospitals' Medicare revenue is received from the Medicare Advantage Program (Part C). Revenues for Part C include capitated payments, which vary based on health status, demographic status, and other factors. Medicare revenues also include accruals for

estimates resulting from changes in health risk factor scores. Such accruals are recognized when the amounts become determinable and collection is reasonably assured. Part C revenue is finalized after all data is submitted to Medicare and the final settlement is made after the end of the year.

In addition, Medicare benefits include a voluntary prescription drug benefit (Part D). Revenues for Part D include capitated payments made from Medicare adjusted for health risk factor scores. Revenues also include amounts to reflect a portion of the health care costs for low-income Medicare beneficiaries and a risk-sharing arrangement to limit the exposure to unexpected expenses. Related accruals are recognized monthly based on cumulative experience and membership data. Part D revenue is finalized after all data is submitted to Medicare and the final settlement is made after the end of the year.

Medicare Part C and D revenue is subject to governmental audits and potential payment adjustments. The Centers for Medicare & Medicaid Services (CMS) performs coding audits to validate the supporting documentation maintained by Health Plans and its care providers.

Certain Medicare revenues are paid under cost reimbursement plans based on pre-established rates, and the final settlement is made after the end of the year. Estimates of final settlements of the cost reports are recorded by Health Plans in current operations.

Estimates of retrospective adjustments resulting from coding audits, cost reports, and other contractual adjustments are recorded in the time period in which members are entitled to health care services. Actual retrospective adjustments may differ from initial estimates.

Premiums collected in advance are deferred and recorded as dues collected in advance or Medicare payments received in advance. Revenue is adjusted to reflect estimates of collectability, including retrospective membership adjustment trends and economic conditions. Revenue and related receivables are exclusive of charity care. A portion of revenues derived under contracts with the United States Office of Personnel Management is subject to audit and potential retrospective adjustments.

Patient services revenue is included in copays, deductibles, fees, and other revenue in the statement of operations and is recognized as services are rendered. Bad debt expense related to patient services revenue is calculated based on historical bad debt experience and recorded as an offset to patient services revenue (net of contractual allowances, charity care, and discounts).

Health Plans provides coverage to certain Medicaid members through contracts with third parties. Third party Medicaid revenue is included in copays, deductibles, fees, and other revenue in the statement of operations. For both years ended December 31, 2016 and 2015, revenues related to these arrangements were $1.4 billion.

(n) Pension and Other Postretirement Benefits

Health Plans' and Hospitals' defined benefit pension and other postretirement benefit plans are actuarially evaluated and involve various assumptions. Critical assumptions include the discount rate

and the expected rate of return on plan assets, and the rate of increase for health care costs (for postretirement benefit plans other than pension), which are important elements of expense and/or liability measurement. Other assumptions involve demographic factors such as retirement age, mortality, turnover, and the rate of compensation increases. Health Plans and Hospitals evaluate assumptions annually, or when significant plan amendments occur, and modify them as appropriate. Pension and other postretirement costs are allocated over the service period of the employees in the plans.

Health Plans and Hospitals use a discount rate to determine the present value of the future benefit obligations. The discount rate is established based on rates available for high-quality fixed-income debt securities at the measurement date whose maturity dates match the expected cash flows of the retirement plans.

Differences between actual and expected plan experience and changes in actuarial assumptions, in excess of a 10% corridor around the larger of plan assets or plan liabilities, are recognized into benefits expense over the expected average future service of active participants. Prior service costs and credits arise from plan amendments and are amortized into postretirement benefits expense over the expected average future service to full eligibility of active participants.

Effective January 1, 2017, Health Plans and Hospitals changed the method used to determine the service and interest cost pertaining to pension and other postretirement benefits expense. Historically, a weighted average discount rate was used in the calculation of service and interest costs. The new method utilizes a "spot rate approach" and provides a more precise measurement of service and interest costs by applying the spot rate along an interest rate yield curve for each expected future cash flow of a retirement plan. This change is considered a change in accounting estimate that is inseparable from a change in accounting principle and accordingly will be accounted for prospectively. It is estimated the spot rate approach will result in a reduction in pension and other postretirement benefits expense of approximately $280 million during 2017.

(o) Donations and Grants Made or Received

Donations and grants made are recognized at fair value in the period in which a commitment is made, provided the payment of the donation or grant is probable and the amount is determinable. Donations or grants received, including research grants, are recognized at fair value in the period the donation or grant was committed unconditionally by the grantor or in the period the donation or grant requirements are met, if later.

(p) Use of Estimates

The preparation of these combined financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts. Allowance for uncollectible accounts receivable; estimated fair value of investments; Medicare revenue accruals; Medicare reserves; incurred but not reported medical claims payable; physicians' retirement plan liabilities; pension and other retirement liabilities; premium deficiency reserves; self-insured

professional liabilities; self-insured general and workers' compensation liabilities; land, buildings, equipment, and software impairment and useful lives; investment impairment; and certain amounts accrued related to the PPACA Reinsurance, Risk Adjustment, and Risk Corridors Programs represent significant estimates. Actual results could differ materially from those estimates. As occurs from time to time, negotiations with labor partners may result in changes to compensation and benefits. These changes are reflected in the financial statements as appropriate when agreements are finalized.

(q) Reclassifications

Certain reclassifications have been made in these combined financial statements to conform 2015 information to the 2016 presentation.

(r) The PPACA Health Insurance Providers Fee, Reinsurance, Risk Adjustment, and Risk Corridors Programs

The PPACA requires Health Plans to pay a Health Insurance Providers (HIP) fee that is assessed based on Health Plans' prior year net premiums as a percentage of total premiums for all U.S. health plans. The Internal Revenue Service (IRS) has provided Health Plans its final assessment of $498 million for 2016, and the amount was paid and expensed in 2016. The 2017 HIP fee was suspended for the 2017 calendar year.

The PPACA also includes three programs designed to mitigate health plan risk. Two are temporary and one is permanent.

The Reinsurance Program is temporary, and provides for partial reimbursement of certain high cost claims for non-grandfathered individual members, beginning in 2014 and continuing through 2016. As described in the *Summary of Significant Accounting Policies - Medical Claims Payable* note, certain amounts have been recorded in 2016 and 2015 as expected claims reimbursements under this program. For the years ended December 31, 2016 and 2015, Health Plans has recorded $146 million and $301 million, respectively, for estimated recoveries from the Reinsurance Program. For the years ended December 31, 2016 and 2015, Health Plans has recorded $218 million and $342 million, respectively, of Reinsurance fees.

The Risk Adjustment Program is permanent, and provides for retrospective adjustment of revenue for non-grandfathered individual and small group market plans, whether inside or outside PPACA exchanges. The Risk Adjustment Program is designed such that payments to plans with higher relative risk are funded by transfers from plans with lower relative risk. For the years ended December 31, 2016 and 2015, Health Plans has recorded $845 million and $11 million, respectively, in net revenue reductions related to the Risk Adjustment Program.

The Risk Corridors Program is temporary, beginning in 2014 and continuing through 2016. This program provides for gains and losses on the individual and small group market plans. For the years ended December 31, 2016 and 2015, Health Plans has recorded $7 million and $(66) million, respectively, in net revenue increases (reductions) related to the Risk Corridors Program.

At December 31, the net receivables (payables) for PPACA Reinsurance recoveries, Risk Adjustment settlements, and Risk Corridors settlements were as follows (in millions):

	2016	2015
Reinsurance recoveries	$ 150	$ 229
Risk Adjustment settlements	(654)	(39)
Risk Corridors settlements	1	(5)
Total	$ (503)	$ 185

(s) Recently Issued Accounting Standards

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2014-09 *Revenue from Contracts with Customers (Topic 606)*. The ASU will replace most existing revenue recognition guidance in U.S. GAAP when it becomes effective. The new standard is effective for Health Plans and Hospitals on January 1, 2018, as amended by ASU No. 2015-14 *Revenue from Contracts with Customers (Topic 606): Deferral of the Effective Date*. The standard permits the use of either the retrospective or cumulative effect transition method. Management has not yet selected a transition method. Additional disclosures will be added as required by the standard.

Management is currently evaluating the impact of adoption on the combined financial statements and related disclosures. Management has analyzed contracts with customers, accounting policies, and has held discussions with key internal stakeholders. There are significant variable revenues recognized by Health Plans and Hospitals that management is in the process of evaluating. Management's current practice for recognizing these variable revenues is using a best estimate approach.

In February 2015, the FASB issued ASU No. 2015-02 *Consolidation (Topic 810)*. The amendments in this update affect reporting entities that are required to evaluate whether they should consolidate certain legal entities. The new standard is effective for Health Plans and Hospitals on January 1, 2017. Early application is permitted. Management has evaluated this accounting standard and it is not expected to have a significant effect on the combined financial statements and related disclosures.

In April 2015, the FASB issued ASU No. 2015-03 *Interest - Imputation of Interest (Subtopic 835-30)*. The amendments in this update require that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, consistent with debt discounts. The new standard was adopted by Health Plans and Hospitals as of January 1, 2016. The standard requires retrospective treatment at adoption and there were $29 million of accrued debt issuance costs at December 31, 2015 presented within other long-term assets, which have been reclassified as a reduction to long-term debt. At December 31, 2016, accrued debt issuance costs were $23 million.

In April 2015, the FASB issued ASU No. 2015-05 *Intangibles - Goodwill and Other - Internal-Use Software (Subtopic 350-40)*. The amendments in this update provide guidance to customers about

whether a cloud computing arrangement includes a software license. The new standard was adopted by Health Plans and Hospitals in 2016. Management has selected the prospective transition method. The adoption of this standard did not have a significant effect on the combined financial statements and related disclosures.

In July 2015, the FASB issued ASU No. 2015-11 *Inventory - Simplifying the Measurement of Inventory (Topic 330)*. The amendments in this update change the measurement principle for inventory from the lower of cost or market to lower of cost and net realizable value. The new standard is effective for Health Plans and Hospitals on January 1, 2017. The standard requires the application of the prospective transition method. Management has evaluated this accounting standard and it is not expected to have a significant effect on the combined financial statements and related disclosures.

In January 2016, the FASB issued ASU No. 2016-01 *Financial Instruments - Overall (Subtopic 825-10)*. The standard requires entities to measure equity investments that are not accounted for under the equity method or do not result in consolidation to be recorded at fair value and recognize any changes in fair value to net income. Investments that qualify for a practicability exception would not require a change in accounting. The disclosure of fair value of investments held at amortized cost will no longer be required. The new standard is effective for Health Plans and Hospitals on January 1, 2019. Early application is permitted but not earlier than January 1, 2018. The standard requires the use of the cumulative effect transition method, except for equity securities without readily determinable fair values, for which the standard requires the application of the prospective transition method. The impact of adoption will result in the change in fair value of available for sale equity securities being reflected in net income and a reduction in the fair value disclosures for certain securities carried at amortized cost.

In February 2016, the FASB issued ASU No. 2016-02 *Leases (Topic 842)*. The standard introduces new requirements to increase transparency and comparability among organizations for leasing transactions for both lessees and lessors. ASU No. 2016-02 requires a lessee to record a right-of-use asset and a lease liability for all leases with terms longer than 12 months. These leases will be either finance or operating, with classification affecting the pattern of expense recognition. The new standard is effective for Health Plans and Hospitals on January 1, 2019. Early application is permitted. The standard requires the application of the modified retrospective transition method. Additional disclosures will be added as required by the standard.

Management is in the process of evaluating necessary changes to information technology systems, accounting policies, and processes to support the adoption of the standard. Management expects to record significant amounts for right-of-use assets and lease liabilities on its combined balance sheets from a lessee perspective. Health Plans and Hospitals do not have significant lessor activity.

In March 2016, the FASB issued ASU No. 2016-07 *Investments - Equity Method and Joint Ventures (Topic 323).* The amendments in this update eliminate the requirement to retroactively adopt the equity method of accounting when an investment qualifies for the use of the equity method as a result of an increase in the level of ownership or degree of influence. The new standard is effective for Health Plans and Hospitals on January 1, 2017. The standard requires the use of the prospective transition method. Management has evaluated this accounting standard and it is not expected to have a significant effect on the combined financial statements and related disclosures.

In June 2016, the FASB issued ASU No. 2016-13 *Financial Instruments - Credit Losses (Topic 326).* The amendments in this update replace the incurred loss impairment methodology in current GAAP with a methodology that reflects expected credit losses and requires consideration of a broader range of reasonable and supportable information to inform credit loss estimates. The new standard is effective for Health Plans and Hospitals on January 1, 2021. Early application is permitted but not earlier than January 1, 2019. The standard requires the use of the cumulative effect transition method, except for debt securities for which an other-than-temporary impairment had been recognized before the effective date, for which the standard requires the application of the prospective transition method. Management has evaluated this accounting standard and it is not expected to have a significant effect on the combined financial statements and related disclosures.

In August 2016, the FASB issued ASU No. 2016-14 *Not-for-Profit Entities (Topic 958).* The amendments in this update make certain improvements that address many, but not all, of the identified issues about the current financial reporting for not-for-profits. The new standard is effective for Health Plans and Hospitals on January 1, 2018. Early application is permitted. The standard requires the use of the retrospective transition method. Management is evaluating the effect that ASU No. 2016-14 will have on its combined financial statements and related disclosures. Management has not determined the effect of the standard on its ongoing financial reporting.

In August 2016, the FASB issued ASU No. 2016-15 *Statement of Cash Flows (Topic 230), Classification of Certain Cash Receipts and Cash Payments.* The amendments in this update address eight specific cash flow issues with the objective of reducing the existing diversity in practice. The new standard is effective for Health Plans and Hospitals on January 1, 2019. Early application is permitted. The standard requires the use of the retrospective transition method. Management is evaluating the effect that ASU No. 2016-15 will have on its combined financial statements and related disclosures. Management has not determined the effect of the standard on its ongoing financial reporting.

(3) Acquisition of Group Health Cooperative and Maui Health System Agreement

Acquisition of Group Health Cooperative

On February 1, 2017, Kaiser Foundation Health Plan of Washington (KFHPW), a subsidiary of Health Plan Inc., acquired and became the sole corporate member of Group Health Cooperative (GHC), a Washington nonprofit corporation. After closing of the acquisition, GHC will remain the sole shareholder of Group Health Options, Inc. (GHO), a Washington for-profit corporation (GHC and its subsidiaries are collectively

referred to herein as, Group Health). Following the acquisition, KFHPW was renamed "KFHPW Holdings" (Holdings), GHC was renamed "Kaiser Foundation Health Plan of Washington," and GHO was renamed "Kaiser Foundation Health Plan of Washington Options, Inc.".

Group Health offers comprehensive, coordinated health care to an enrolled membership primarily for a fixed fee through its owned and leased facilities, employed providers, and contracted providers. In addition, Group Health provides certain health care services on a fee for service basis to both enrollees and nonenrollees. Through this acquisition, Health Plans expects to better meet the needs of individuals as well as large commercial and national accounts with employees who live and work in Washington.

Following execution of a definitive Acquisition Agreement on December 2, 2015, $2 billion was transferred from Hospitals to Holdings and restricted for purposes of completing this acquisition and related transactions. At December 31, 2016, this restricted asset is included in current investments in the combined financial statements. At closing, Holdings transferred approximately $1.8 billion in cash, of which $75 million was deposited into escrow for possible future indemnity claims. In addition to and separate from this transaction consideration, the Acquisition Agreement requires $1 billion to be spent over the 10 year period following closing (subject to standard capital and budget approval processes) for capital improvements and key investments in infrastructure and other improvements at Group Health, and also states that $800 million in community benefit contributions is expected to be made over the same period.

Group Health and Group Health Permanente, P.C. (GHP), an independent Washington professional services corporation, have an existing exclusive arrangement for the provision of physician and certain other medical services to Group Health enrollees. As part of the successful completion of the Group Health acquisition, Holdings and GHP entered into agreements to continue that arrangement following closing of the Group Health acquisition, including payments to GHP of up to $200 million, recognized primarily as operating expenses and intangible assets.

Due to the limited time since the closing of the Group Health acquisition, the valuation activities and related acquisition accounting are incomplete at this time. As a result, the purchase price allocation and other acquisition related disclosures have not been provided.

Maui Health System Agreement

In January 2016, Maui Health System, A Kaiser Foundation Hospitals LLC (MHSKFH), a subsidiary of Hospitals, entered into a contract with State of Hawaii entities to manage, operate, and provide health care services at hospitals of the Maui Region of Hawaii Health Systems Corporation under the terms of a 30 year transfer agreement. The agreement includes an option for MHSKFH to extend for a potential of two more 10 year terms. Certain existing facilities will be leased from the State of Hawaii entities with financial responsibility of any additional investments to the facilities to be shared between MHSKFH and the State of Hawaii entities during the first 10 years, and MHSKFH will be eligible to receive annual operating support from the State of Hawaii. The transfer is expected to be completed on July 1, 2017.

(4) Fair Value Estimates

The carrying amounts reported in the balance sheets for cash and cash equivalents, securities lending collateral, broker receivables, accounts receivable - net, accounts payable and accrued expenses, medical claims payable, due to associated medical groups, payroll and related charges, securities lending payable, and broker payables approximate fair value.

Investments, other than alternative investments, as discussed in the *Investments* note, are reported at fair value. The fair values of investments are based on quoted market prices, if available, or estimated using quoted market prices for similar investments. If listed prices or quotes are not available, fair value is based upon other observable inputs or models that primarily use market-based or independently sourced market parameters as inputs. In addition to market information, models also incorporate transaction details such as maturity. Fair value adjustments, including credit, liquidity, and other factors, are included, as appropriate, to arrive at a fair value measurement. Certain investments are illiquid and are valued based on the most current information available, which may be less current than the date of these combined financial statements.

The carrying value of alternative investments, which include absolute return, risk parity, and private equity, is reported under the equity method, which management believes to approximate fair value. The fair values of alternative investments have been estimated by management based on all available data, including information provided by fund managers or the general partners. The underlying securities within absolute return investments are typically valued using quoted prices for identical or similar instruments within active and inactive markets. The underlying holdings within private equity investments are valued based on recent transactions, operating results, and industry and other general market conditions.

Health Plans and Hospitals utilize a three-level valuation hierarchy for fair value measurements. An instrument's categorization within the hierarchy is based upon the lowest level of input that is significant to the fair value measurement. For instruments classified in level 1 of the hierarchy, valuation inputs are quoted prices for identical instruments in active markets at the measurement date. For instruments classified in level 2 of the hierarchy, valuation inputs are directly observable but do not qualify as level 1 inputs. Examples of level 2 inputs include: quoted prices for similar instruments in active markets; quoted prices for identical or similar instruments in inactive markets; other observable inputs such as interest rates and yield curves observable at commonly quoted intervals, volatilities, prepayment speeds, loss severities, credit risks, and default rates; and market-correlated inputs that are derived principally from or corroborated by observable market data. For instruments classified in level 3 of the hierarchy, valuation inputs are unobservable inputs for the instrument. Level 3 inputs incorporate assumptions about the factors that market participants would use in pricing the instrument.

The fair value of long-term debt is based on level 2 inputs for debt with similar risk, terms, and remaining maturities. At December 31, 2016 and 2015, the carrying amount of long-term debt totaled $5.6 billion and $6.9 billion, respectively. At December 31, 2016 and 2015, the estimated fair value of long-term debt was approximately $5.7 billion and $7.1 billion, respectively.

At December 31, 2016 and 2015, Health Plans and Hospitals held derivative financial instruments including interest rate swaps, as well as futures, swaps, and forwards held within investment portfolios. The estimated fair values of derivative instruments were determined using level 2 inputs, including available market information and valuation methodologies, primarily discounted cash flows. Additional description and the fair value of derivative instruments are contained in the *Derivative Instruments* note.

(5) Investments

Management's methods for estimating fair value of financial instruments are discussed in the *Fair Value Estimates* note.

At December 31, 2016, the estimated fair value of current investments by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
U.S. equity securities	$ 24	$ —	$ —	$ 24
Debt securities issued by the U.S. government	—	3,200	—	3,200
Debt securities issued by U.S. government agencies and corporations	—	58	—	58
Debt securities issued by U.S. states and political subdivisions of states	—	61	—	61
Foreign government debt securities	—	90	—	90
U.S. corporate debt securities	—	2,267	—	2,267
Foreign corporate debt securities	—	1,009	—	1,009
U.S. agency mortgage-backed securities	—	735	—	735
Non-U.S. agency mortgage-backed securities	—	216	—	216
Other asset-backed securities	—	723	—	723
Short-term investment funds	—	294	—	294
Total	$ 24	$ 8,653	$ —	$ 8,677

At December 31, 2016, the estimated fair value of noncurrent investments by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
U.S. equity securities	$ 3,744	$ 164	$ —	$ 3,908
Foreign equity securities	2,690	1,455	—	4,145
Global equity funds	—	451	—	451
Debt securities issued by the U.S. government	—	1,238	—	1,238
Debt securities issued by U.S. government agencies and corporations	—	100	—	100
Debt securities issued by U.S. states and political subdivisions of states	—	182	—	182
Foreign government debt securities	—	1,157	—	1,157
U.S. corporate debt securities	—	3,566	—	3,566
Foreign corporate debt securities	—	1,387	—	1,387
U.S. agency mortgage-backed securities	—	614	—	614
Non-U.S. agency mortgage-backed securities	—	235	8	243
Other asset-backed securities	—	241	—	241
Short-term investment funds	—	1,021	—	1,021
Other	143	518	1	662
Alternative investments:				
Absolute return	—	1,165	911	2,076
Private equity	—	—	4,089	4,089
Risk parity	—	—	676	676
Total	$ 6,577	$ 13,494	$ 5,685	$ 25,756

At December 31, 2015, the estimated fair value of current investments by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
U.S. equity securities	$ 31	$ —	$ —	$ 31
Debt securities issued by the U.S. government	—	1,500	—	1,500
Debt securities issued by U.S. government agencies and corporations	—	48	—	48
Debt securities issued by U.S. states and political subdivisions of states	—	56	—	56
Foreign government debt securities	—	40	—	40
U.S. corporate debt securities	—	2,003	—	2,003
Foreign corporate debt securities	—	966	—	966
U.S. agency mortgage-backed securities	—	660	—	660
Non-U.S. agency mortgage-backed securities	—	351	—	351
Other asset-backed securities	—	593	—	593
Short-term investment funds	—	297	—	297
Other	—	9	—	9
Total	$ 31	$ 6,523	$ —	$ 6,554

At December 31, 2015, the estimated fair value of noncurrent investments by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
U.S. equity securities	$ 3,538	$ 10	$ —	$ 3,548
Foreign equity securities	2,888	1,281	—	4,169
Global equity funds	—	751	—	751
Debt securities issued by the U.S. government	—	1,139	—	1,139
Debt securities issued by U.S. government agencies and corporations	—	117	—	117
Debt securities issued by U.S. states and political subdivisions of states	—	184	—	184
Foreign government debt securities	—	1,101	—	1,101
U.S. corporate debt securities	—	3,322	—	3,322
Foreign corporate debt securities	—	1,407	—	1,407
U.S. agency mortgage-backed securities	—	663	—	663
Non-U.S. agency mortgage-backed securities	—	179	11	190
Other asset-backed securities	—	196	—	196
Short-term investment funds	—	2,613	—	2,613
Other	82	429	1	512
Alternative investments:				
Absolute return	—	1,272	964	2,236
Private equity	—	—	3,234	3,234
Risk parity	—	—	807	807
Total	$ 6,508	$ 14,664	$ 5,017	$ 26,189

At December 31, 2016, debt and equity securities available-for-sale were as follows (in millions):

	Amortized cost	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. equity securities	$ 3,267	$ 665	$ —	$ 3,932
Foreign equity securities	3,562	583	—	4,145
Global equity funds	359	92	—	451
Debt securities issued by the U.S. government	4,427	11	—	4,438
Debt securities issued by U.S. government agencies and corporations	152	6	—	158
Debt securities issued by U.S. states and political subdivisions of states	215	28	—	243
Foreign government debt securities	1,190	57	—	1,247
U.S. corporate debt securities	5,571	262	—	5,833
Foreign corporate debt securities	2,316	80	—	2,396
U.S. agency mortgage-backed securities	1,338	11	—	1,349
Non-U.S. agency mortgage-backed securities	451	8	—	459
Other asset-backed securities	949	15	—	964
Short-term investment funds	1,315	—	—	1,315
Other	650	12	—	662
Total	$ 25,762	$ 1,830	$ —	$ 27,592

At December 31, 2015, debt and equity securities available-for-sale were as follows (in millions):

	Amortized cost	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. equity securities	$ 3,031	$ 548	$ —	$ 3,579
Foreign equity securities	3,657	512	—	4,169
Global equity funds	506	245	—	751
Debt securities issued by the U.S. government	2,630	9	—	2,639
Debt securities issued by U.S. government agencies and corporations	158	7	—	165
Debt securities issued by U.S. states and political subdivisions of states	214	26	—	240
Foreign government debt securities	1,109	32	—	1,141
U.S. corporate debt securities	5,225	100	—	5,325
Foreign corporate debt securities	2,347	26	—	2,373
U.S. agency mortgage-backed securities	1,311	12	—	1,323
Non-U.S. agency mortgage-backed securities	534	7	—	541
Other asset-backed securities	782	7	—	789
Short-term investment funds	2,910	—	—	2,910
Other	521	—	—	521
Total	$ 24,935	$ 1,531	$ —	$ 26,466

At December 31, available-for-sale debt securities by contractual maturity and mortgage-backed and other asset-backed debt securities were as follows (in millions):

	2016		2015	
	Amortized cost	Fair value	Amortized cost	Fair value
Due in one year or less	$ 2,356	$ 2,362	$ 3,585	$ 3,587
Due after one year through five years	7,604	7,702	5,852	5,881
Due after five years through ten years	2,563	2,671	2,536	2,567
Due after ten years	3,313	3,557	3,141	3,279
U.S. agency mortgage-backed securities	1,338	1,349	1,311	1,323
Non-U.S. agency mortgage-backed securities	451	459	534	541
Other asset-backed securities	949	964	782	789
Total	$ 18,574	$ 19,064	$ 17,741	$ 17,967

For the year ended December 31, 2016, the reconciliation of investments with fair value measurements using significant unobservable inputs (level 3) was as follows (in millions):

	Debt securities	Alternative investments	Total
Beginning balance	$ 12	$ 5,005	$ 5,017
Transfers out of level 3	—	(9)	(9)
Total net losses:			
Realized	1	249	250
Unrealized	—	—	—
Purchases	1	1,364	1,365
Sales	(1)	(933)	(934)
Settlements	(4)	—	(4)
Ending balance	$ 9	$ 5,676	$ 5,685
Total realized and unrealized year-to-date net gains related to assets held at December 31, 2016	$ —	$ 223	$ 223

For the year ended December 31, 2015, the reconciliation of investments with fair value measurements using significant unobservable inputs (level 3) was as follows (in millions):

	Equity securities	Debt securities	Alternative investments	Total
Beginning balance	$ 26	$ 14	$ 3,501	$ 3,541
Transfers out of level 3	(28)	—	—	(28)
Total net gains (losses):				
Realized	1	1	(42)	(40)
Unrealized	6	(1)	—	5
Purchases	—	—	1,834	1,834
Sales	(5)	—	(288)	(293)
Settlements	—	(2)	—	(2)
Ending balance	$ —	$ 12	$ 5,005	$ 5,017
Total realized and unrealized year-to-date net gains (losses) related to assets held at December 31, 2015	$ 5	$ —	$ (42)	$ (37)

Transfers between fair value input levels, if any, are recorded at the end of the reporting period. Transfers between fair value input levels occur when valuation inputs used to record or disclose assets or liabilities change from one level of the valuation hierarchy to another. During the years ended December 31, 2016

and 2015, there were no transfers between assets with inputs with quoted prices in active markets for identical assets (level 1) and assets with inputs with significant other observable inputs (level 2).

Investments include specific funds held in trust accounts related to collateral requirements for certain reinsurance agreements. At December 31, 2016 and 2015, the values of these funds were $44 million and $53 million, respectively.

Absolute return investments use advanced investment strategies, including derivatives, to generate positive long-term risk adjusted returns. Private equity investments consist of funds that make direct investments in private companies. Risk parity funds use risk as the primary factor to allocate investments among asset classes. Management meets with alternative investment fund managers periodically to assess portfolio performance and reporting and exercises oversight over fund managers. At December 31, 2016, Hospitals had original commitments related to alternative investments of $7.9 billion, of which $4.7 billion was invested, leaving $3.2 billion of remaining commitments. At December 31, 2015, Hospitals had original commitments related to alternative investments of $6.7 billion, of which $3.7 billion was invested, leaving $3.0 billion of remaining commitments.

For the years ended December 31, investment income - net was comprised of the following (in millions):

	2016	2015
Other-than-temporary impairment	$ (622)	$ (1,426)
Recognized gains	1,349	1,401
Recognized losses	(344)	(299)
Income from equity method alternative investments	532	152
Interest, dividends, and other income - net	876	771
Derivative income	15	136
Total investment income - net	1,806	735
Less investment income included in operating income	(427)	(435)
Investment income - net	$ 1,379	$ 300

For the years ended December 31, 2016 and 2015, Health Plans and Hospitals recorded impairment of certain investments in accordance with the policy described in the *Summary of Significant Accounting Policies - Investments* note. During the years ended December 31, 2016 and 2015, there was $2 million and $1 million, respectively, of impairment of alternative investments.

Absolute return, risk parity, and private equity investments include redemption restrictions. Absolute return and risk parity investments require 10 to 90 day written notice of intent to withdraw and are often subject to the approval and capital requirements of the fund manager. Absolute return and risk parity investments of $599 million are subject to lock-up periods of up to 3 years. Private equity agreements do not include provisions for redemption. Distributions will be received as the underlying investments of the funds are liquidated, which is expected over the next 11 years.

The majority of debt and equity securities can be redeemed within 10 days. Debt and equity investment funds of $1.2 billion are redeemable between 10 and 30 days. Equity investment funds of $282 million have a redemption period of between 30 days and 1 year. No debt or equity investments require a redemption period of greater than 1 year.

(6) Derivative Instruments

(a) Interest Rate Swaps

At both December 31, 2016 and 2015, Health Plans and Hospitals had 11 agreements to manage interest rate fluctuations (Interest Rate Swaps) with a total notional amount of $1.2 billion. At December 31, 2016 and 2015, the fair values of these agreements were $(251) million and $(274) million, respectively, and were recorded in other long-term liabilities. For the years ended December 31, 2016 and 2015, Health Plans and Hospitals recorded $33 million and $35 million, respectively, in interest expense relating to the Interest Rate Swaps. For the years ended December 31, 2016 and 2015, net changes in fair values totaled $23 million and $(7) million, respectively, and were recorded in investment income - net.

These derivatives contain reciprocal provisions whereby if Health Plans' and Hospitals' or the counterparties' credit rating was to decline to certain levels, provisions would be triggered requiring Health Plans and Hospitals or the counterparties to provide certain collateral. At December 31, 2016 and 2015, no collateral was required to be posted by either Health Plans and Hospitals or the counterparties.

(b) Derivatives Held in Investment Portfolios

At December 31, 2016 and 2015, Health Plans' and Hospitals' portfolio managers held $46 million and $(3) million, respectively, of futures, forwards, options, and swaps to attempt to protect investments against volatility. For the years ended December 31, 2016 and 2015, net changes in fair values totaled $59 million and $(9) million, respectively, and were recorded in investment income - net. For the years ended December 31, 2016 and 2015, gains (losses) resulting from derivative settlements totaled $(67) million and $152 million, respectively, and were recorded in investment income - net.

(c) Information on Derivative Gain (Loss) and Fair Value

Management's methods for estimating fair value of financial instruments are discussed in the *Fair Value Estimates* note.

Information on Derivative Gain (Loss) Mark-to-Market Valuation Recognized in Income

(In millions)

Derivatives not designated as hedging instruments	Statement of operations category	Gain (loss) recognized in income on derivatives for the years ended December 31, 2016	2015
Interest rate swaps - related to debt	Investment income - net	$ 23	$ (7)
Interest rate swaps - other	Investment income - net	31	1
Options, rights, and warrants	Investment income - net	(1)	19
Futures and forwards	Investment income - net	29	(29)
		$ 82	$ (16)

Information on Derivative Settlement Costs Recognized in Income

(In millions)

Derivatives not designated as hedging instruments	Statement of operations category	Gain (loss) recognized in income on derivatives for the years ended December 31, 2016	2015
Interest rate swaps - related to debt	Interest expense	$ (33)	$ (35)
Interest rate swaps - other	Investment income - net	(4)	(51)
Futures and forwards	Investment income - net	(83)	202
Options, rights, and warrants	Investment income - net	20	1
		$ (100)	$ 117

Information on Fair Value of Derivative Instruments - Assets

(In millions)

Derivatives not designated as hedging instruments	Balance sheet category	Fair value at December 31, 2016	2015
Interest rate swaps - other	Noncurrent investments	$ 47	$ 13
Futures and forwards	Noncurrent investments	64	33
Options, rights, and warrants	Noncurrent investments	7	1
		$ 118	$ 47

Information on Fair Value of Derivative Instruments - Liabilities

(In millions)

Derivatives not designated as hedging instruments	Balance sheet category	Fair value at December 31, 2016	2015
Interest rate swaps - related to debt	Other long-term liabilities	$ 251	$ 274
Interest rate swaps - other	Other long-term liabilities	25	22
Futures and forwards	Other long-term liabilities	38	25
Options, rights, and warrants	Other long-term liabilities	9	3
		$ 323	$ 324

(7) Accounts Receivable - net

At December 31, accounts receivable - net were as follows (in millions):

	2016	2015
Members' dues	$ 799	$ 709
Patient services	387	390
Medicare	315	317
Reinsurance recoveries	150	231
Risk Adjustment receivables	15	66
Other	564	399
	2,230	2,112
Allowances for bad debt	(200)	(146)
Total	$ 2,030	$ 1,966

(8) Inventories and Other Current Assets

At December 31, inventories and other current assets were as follows (in millions):

	2016	2015
Inventories - net	$ 832	$ 871
Prepaid expenses	455	481
Other	70	70
Total	$ 1,357	$ 1,422

(9) Land, Buildings, Equipment, and Software - net

At December 31, land, buildings, equipment, and software - net were as follows (in millions):

	2016	2015
Land	$ 1,884	$ 1,821
Buildings and improvements	32,627	30,761
Furniture, equipment, and software	11,654	10,791
Construction and software development in progress	1,379	1,920
	47,544	45,293
Accumulated depreciation and amortization	(23,202)	(21,511)
Total	$ 24,342	$ 23,782

Health Plans and Hospitals capitalize interest costs on borrowings incurred during the construction, upgrade, or development of qualifying assets. Capitalized interest is added to the cost of the underlying assets and is depreciated or amortized over the useful lives of the assets. During the years ended December 31, 2016 and 2015, Health Plans and Hospitals capitalized $26 million and $28 million, respectively, of interest in connection with various capital projects.

Asset retirement obligations relate primarily to the following: leased building restoration, building materials containing asbestos, leaded wall shielding, storage tanks (above ground and below ground), chillers or cooling tower chemicals, mercury in large fixed-components, and hard drives requiring data wiping prior to disposal. At December 31, 2016 and 2015, the liability for asset retirement obligations was $103 million and $85 million, respectively. At December 31, 2016 and 2015, the unamortized asset related to these retirement obligations was $19 million and $13 million, respectively.

(10) Medical Claims Payable

For the years ended December 31, activity in the liability for medical claims payable was as follows (in millions):

	2016	2015
Balances at January 1	$ 1,750	$ 1,393
Incurred related to:		
Current year	9,117	8,342
Prior years	(144)	(33)
Total incurred	8,973	8,309
Paid related to:		
Current year	7,415	6,795
Prior years	1,446	1,157
Total paid	8,861	7,952
Balances at December 31	$ 1,862	$ 1,750

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately adjudicated and paid. Liabilities are reviewed and revised as information regarding actual claims payments becomes known. Negative amounts reported for incurred related to prior years result from claims being adjudicated and paid for amounts less than originally estimated.

(11) Other Liabilities

At December 31, other current liabilities were as follows (in millions):

	2016	2015
Self-insured risks	$ 388	$ 393
Dues collected in advance	682	628
Medicare liabilities	33	45
Physicians' retirement plan liability	185	171
TBA commitments	136	149
Other	678	641
Total	$ 2,102	$ 2,027

At December 31, other long-term liabilities were as follows (in millions):

	2016	2015
Self-insured risks	$ 1,518	$ 1,500
Derivatives liability	323	324
Due to associated medical groups	202	289
Other	337	305
Total	$ 2,380	$ 2,418

(12) Debt

At December 31, debt was as follows (in millions):

	2016	2015
Tax-exempt revenue bonds and taxable bonds and notes:		
0.01% to 2.00% variable rate due through 2052	$ 5,107	$ 4,097
3.60% to 5.25% fixed rate due through 2045	2,329	3,468
Others at various rates due through 2026	7	2
Total	$ 7,443	$ 7,567
Other current debt:		
Commercial paper	$ 1,886	$ 654
Current portion of long-term debt	18	121
Long-term debt subject to short-term remarketing arrangements - net	785	732
Long-term debt classified as a long-term liability	4,754	6,060
Total	$ 7,443	$ 7,567

At December 31, 2016 and 2015, repurchase of variable rate bonds totaling $3.2 billion and $3.4 billion, respectively, may be required at earlier than stated maturity. These bonds may be remarketed rather than repurchased. Health Plans and Hospitals have provided self liquidity for the variable rate demand bonds with put options. Additionally, at December 31, 2016 and 2015, management had the ability to finance the acquisition of up to $2.4 billion of any unremarketed bonds that are put, using available credit facilities. At December 31, 2016 and 2015, $785 million and $732 million, respectively, of these variable rate demand bonds were classified in current liabilities, net of available long-term credit facilities of $2.4 billion.

At December 31, 2016 and 2015, $31 million and $52 million, respectively, of the above tax-exempt fixed-rate revenue bonds represented a net unamortized premium balance. At December 31, 2016 and 2015, $(23) million and $(29) million, respectively, of unamortized debt issuance cost was presented within long-term debt.

Scheduled principal payments for each of the next five years and thereafter considering obligations subject to short-term remarketing as due according to their long-term amortization schedule, except as described below, were as follows (in millions):

2017	$	1,904
2018		18
2019		247
2020		18
2021		18
Thereafter		5,230
Total	$	7,435

At December 31, 2016, Hospitals had certain bonds that require mandatory tender by the holder on a date certain in the amount of $275 million in 2017. Hospitals intends to remarket these bonds until final maturity of the bonds.

Credit Facility

Hospitals' credit facility of $2.4 billion terminates in September 2021. Various interest rate options are available under this facility. Any revolving borrowings mature on the termination date. Hospitals pays facility fees, which range from 0.05% to 0.15% per annum, depending upon Hospitals' long-term senior unsecured debt rating. At December 31, 2016, the facility fee was at an annual rate of 0.06%. At December 31, 2016 and 2015, no amounts were outstanding under this credit facility.

Hospitals' revolving credit facility contains a financial covenant. Under the terms of this facility, Hospitals is required to maintain a ratio of total debt to capital, as defined.

Taxable Commercial Paper Program

Hospitals maintains a commercial paper program providing for the issuance of up to $2.4 billion in aggregate maturity value of short-term indebtedness. The commercial paper is issued in denominations of $100,000 and will bear such interest rates, if interest-bearing, or will be sold at such discount from their face amounts, as agreed upon by Hospitals and the dealer acting in connection with the commercial paper program. The commercial paper may be issued with varying maturities up to a maximum of 270 days from the date of issuance. At December 31, 2016 and 2015, commercial paper of $1.9 billion and $654 million, respectively, was outstanding under this program and is included within other current debt.

(13) Pension Plans

(a) Defined Benefit Plan

Health Plans and Hospitals have a defined benefit pension plan (Plan) covering substantially all their employees. Benefits are based on age at retirement, years of credited service, and average

compensation for a specified period prior to retirement. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future.

For financial reporting purposes, the projected unit credit method is used. At December 31, 2016 and 2015, substantially all pension fund assets were held in a group trust. At December 31, 2016 and 2015, the trust's assets were invested primarily in fixed-income and equity securities, with approximately 21% and 22%, respectively, of trust assets, net of liabilities, invested in alternative investments.

At December 31, the funded status of the Plan was as follows (in millions):

	2016	2015
Change in projected benefit obligation (PBO):		
Benefit obligation at beginning of year	$ 16,536	$ 16,361
Service cost	1,079	1,130
Interest cost	772	713
Plan amendments	—	118
Net actuarial loss (gain)	1,058	(1,137)
Benefits paid	(867)	(649)
Benefit obligation at end of year	$ 18,578	$ 16,536
Accumulated benefit obligation at end of year	$ 14,316	$ 12,846
Change in Health Plans' and Hospitals' share of trust assets:		
Fair value of plan assets at beginning of year	$ 10,149	$ 9,374
Actual return on plan assets	758	(165)
Contributions	1,731	1,589
Benefits paid	(867)	(649)
Fair value of plan assets at end of year	$ 11,771	$ 10,149
Funded status	$ (6,807)	$ (6,387)
Amounts recognized in the balance sheet consist of:		
Noncurrent assets	$ —	$ —
Current liabilities	—	—
Pension and other retirement liabilities	(6,807)	(6,387)
	$ (6,807)	$ (6,387)
Amounts recognized in net worth:		
Net actuarial loss	$ 5,602	$ 4,701
Prior service cost	99	113
	$ 5,701	$ 4,814

The measurement date used to determine pension valuations was December 31.

For the years ended December 31, pension expense was as follows (in millions):

	2016	2015
Service cost	$ 1,079	$ 1,130
Interest cost	772	713
Expected return on plan assets	(810)	(678)
Amortization of net actuarial loss	209	386
Amortization of prior service cost	14	11
Net pension expense	1,264	1,562
Other changes in plan assets and PBO recognized in net worth:		
Net actuarial loss (gain)	1,110	(294)
Prior service cost	—	118
Amortization of net actuarial loss	(209)	(386)
Amortization of prior service cost	(14)	(11)
Total recognized in net worth	887	(573)
Total recognized in net periodic benefit cost and net worth	$ 2,151	$ 989

During 2017, $300 million and $10 million in estimated net actuarial loss and prior service cost, respectively, will be amortized from net worth into net pension expense.

Actuarial assumptions used were as follows:

	2016	2015
Weighted average discount rate at January 1 for calculating pension expense	4.70%	4.25%
Weighted average discount rate for calculating December 31 PBO	4.45%	4.70%
Weighted average salary scale for calculating pension expense	4.20%	4.20%
Weighted average salary scale for calculating December 31 PBO	4.20%	4.20%
Expected long-term rate of return on plan assets for calculating pension expense	7.25%	7.25%

During 2017, management expects to contribute approximately $2.0 billion to the Plan.

The following benefit payments, which reflect expected future service, are expected to be paid (in millions):

2017	$	727
2018		804
2019		889
2020		974
2021		1,062
2022 - 2026		6,316

Explanation of Investment Strategies and Policies

A total return investment approach is employed for the Plan whereby the Plan invests in a mix of equity, fixed-income, and alternative asset classes to maximize the long-term return of plan assets for a prudent level of risk. The intent of this strategy is to minimize plan expenses by outperforming plan liabilities over the long run. Risk tolerance is established through consideration of plan liabilities, plan funded status, and corporate financial condition. The investment portfolio will consist over time of a varying but diversified blend of equity, fixed-income, and alternative investments. Diversification includes such factors as geographic location, equity capitalization size and style, placement in the capital structure, and security type. Investment risk is measured and monitored on an ongoing basis through annual liability measurements, periodic asset/liability studies, and quarterly investment portfolio reviews. The Plan's investment policy has restrictions relating to credit quality, industry/sector concentration, duration, concentration of ownership, and use of derivatives.

Capital Market Assumption Methodology

To determine the long-term rate of return assumption for plan assets, management incorporates historical relationships among the various asset classes and subclasses to be accessed over the investment horizon. Management's intent is to maximize portfolio efficiency. This will be accomplished by seeking the highest returns prudently available among the available asset classes. Overall portfolio volatility is managed through diversification among asset classes. Current market factors such as inflation and interest rates are evaluated before long-term capital market assumptions are determined. From time to time, management reviews its long-term investment strategy and reconciles that strategy with the long-term liabilities of the Plan. This asset-liability study produces a range of expected returns over medium and long-term time periods. Those intermediate and long-term investment projections form the basis for the expected long-term rate of return on assets.

At December 31, 2016, the estimated fair value of total pension trust assets - net by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
Assets:				
Cash and cash equivalents	$ 117	$ 1,018	$ —	$ 1,135
Broker receivables	—	355	—	355
Securities lending collateral	—	979	—	979
U.S. equity securities	5,212	510	—	5,722
Foreign equity securities	4,679	1,834	—	6,513
Global equity funds	—	253	—	253
Debt securities issued by the U.S. government	—	1,036	—	1,036
Debt securities issued by U.S. government agencies and corporations	—	56	—	56
Debt securities issued by U.S. states and political subdivisions of states	—	201	—	201
Foreign government debt securities	—	492	—	492
U.S. corporate debt securities	—	4,256	—	4,256
Non-U.S. corporate debt securities	—	1,037	—	1,037
U.S. agency mortgage-backed securities	—	189	—	189
Non-U.S. agency mortgage-backed securities	—	44	—	44
Other	—	666	—	666
Alternative investments:				
Absolute return	—	496	1,174	1,670
Private equity	—	—	3,241	3,241
Risk parity	—	—	752	752
Total assets	10,008	13,422	5,167	28,597
Liabilities:				
Broker payables	—	508	—	508
Securities lending payable	—	979	—	979
Other liabilities	19	631	—	650
Total liabilities	19	2,118	—	2,137
Fair value of pension trust assets - net	$ 9,989	$ 11,304	$ 5,167	$ 26,460

At December 31, 2016, Health Plans' and Hospitals' share of pension trust assets was 44.5%, or $11.8 billion. The remaining share of pension trust assets is for Medical Groups and a related party associated with Medical Groups.

At December 31, 2015, the estimated fair value of total pension trust assets - net by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
Assets:				
Cash and cash equivalents	$ 110	$ 1,082	$ —	$ 1,192
Broker receivables	—	156	—	156
Securities lending collateral	—	1,332	—	1,332
U.S. equity securities	4,219	365	—	4,584
Foreign equity securities	4,125	1,616	—	5,741
Global equity funds	—	187	—	187
Debt securities issued by the U.S. government	—	841	—	841
Debt securities issued by U.S. government agencies and corporations	—	70	—	70
Debt securities issued by U.S. states and political subdivisions of states	—	199	—	199
Foreign government debt securities	—	486	—	486
U.S. corporate debt securities	—	3,722	—	3,722
Non-U.S. corporate debt securities	—	957	—	957
U.S. agency mortgage-backed securities	—	159	—	159
Non-U.S. agency mortgage-backed securities	—	40	—	40
Other	1	569	—	570
Alternative investments:				
Absolute return	—	900	1,249	2,149
Private equity	—	—	2,339	2,339
Risk parity	—	—	597	597
Total assets	8,455	12,681	4,185	25,321
Liabilities:				
Broker payables	—	282	—	282
Securities lending payable	—	1,332	—	1,332
Other liabilities	12	117	—	129
Total liabilities	12	1,731	—	1,743
Fair value of pension trust assets - net	$ 8,443	$ 10,950	$ 4,185	$ 23,578

At December 31, 2015, Health Plans' and Hospitals' share of pension trust assets was 43.0%, or $10.1 billion. The remaining share of pension trust assets is for Medical Groups and a related party associated with Medical Groups.

For the years ended December 31, reconciliations of alternative investments with fair value measurements using significant unobservable inputs (level 3) were as follows (in millions):

	2016	2015
Beginning balance	$ 4,185	$ 3,103
Transfers into level 3	—	—
Changes related to actual return on plan assets	195	22
Purchases, sales, and settlements - net	787	1,060
Ending balance	$ 5,167	$ 4,185
Total year-to-date net gains related to assets held at end of period	$ 196	$ 21

During the years ended December 31, 2016 and 2015, there were no significant transfers of assets with inputs with quoted prices in active markets for identical assets (level 1) and assets with inputs with significant other observable inputs (level 2).

The target asset allocation and expected long-term rate of return on assets (ELTRA) for calculating pension expense were as follows:

	2016 and 2015 target range	2016 and 2015 ELTRA
Cash and cash equivalents	0%-3%	3.00%
Equity securities	43%-55%	8.65%
Debt securities	28%-45%	5.50%
Alternative investments	10%-25%	7.60%
Total	100%	7.25%

Alternative investments, which include absolute return, risk parity, and private equity, held in the pension trust are reported at net asset value as a practical expedient for fair value. Absolute return investments use advanced investment strategies, including derivatives, to generate positive long-term risk adjusted returns. Private equity investments consist of funds that make direct investments in private companies. Risk parity funds use risk as the primary factor to allocate investments among asset classes. At December 31, 2016, the trust had original commitments related to alternative investments of $6.7 billion, of which $3.4 billion was invested, leaving $3.3 billion of remaining commitments. At December 31, 2015, the trust had original commitments related to alternative investments of $5.4 billion, of which $2.4 billion was invested, leaving $3.0 billion of remaining commitments.

Absolute return, risk parity, and private equity investments include redemption restrictions. Absolute return and risk parity investments require 10 to 90 day written notice of intent to withdraw and are

often subject to the approval and capital requirements of the fund manager. At December 31, 2016, absolute return and risk parity investments of $809 million are subject to lock-up periods of up to 3 years. Private equity agreements do not include provisions for redemption. Distributions will be received as the underlying investments of the funds are liquidated, which is expected over the next 11 years.

The majority of debt and equity securities can be redeemed within 10 days. Debt and equity investment funds of $1.5 billion are redeemable between 10 and 30 days. Equity investment funds of $166 million have a redemption period of up to 120 days. No debt or equity investments require a redemption period of greater than 120 days.

(b) Defined Contribution Plans

Health Plans and Hospitals have defined contribution plans for eligible employees. Employer contributions and costs are typically based on a percentage of covered employees' eligible compensation. During 2016 and 2015, there were no required employee contributions. For the years ended December 31, 2016 and 2015, plan expense, primarily employer contributions, was $257 million and $247 million, respectively.

(c) Multi-Employer Plans

Health Plans and Hospitals participate in a number of multi-employer defined benefit pension plans under the terms of collective bargaining agreements that cover some union-represented employees. Some risks of participating in these multi-employer plans that differ from single-employer plans include:

- Assets contributed to the multi-employer plan by one employer may be used to provide benefits to employees of other participating employers.
- If a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers.
- Employers that choose to stop participating in a multi-employer plan may be required to pay the plan an amount based on the underfunded status of the plan, referred to as a withdrawal liability.

Health Plans' and Hospitals' participation in these plans for the year ended December 31, 2016 is outlined in the table below. The "EIN/PN" column provides the Employee Identification Number (EIN) and the three-digit plan number (PN), if applicable. Unless otherwise noted, the most recent Pension Protection Act (PPA) zone status available in 2016 and 2015 is for the plan's year-end in 2015 and 2014, respectively. The zone status is based on information that Health Plans and Hospitals obtained from publicly available information provided by the United States Department of Labor. Among other factors, plans in the red zone are generally less than 65% funded, plans in the yellow zone are between 65% and 80% funded, and plans in the green zone are at least 80% funded. The

"FIP/RP Status Pending/Implemented" column indicates plans for which a financial improvement plan (FIP) or a rehabilitation plan (RP) is either pending or has been implemented. The "Health Plans' and Hospitals' Contributions to Plan Exceeded More Than 5% of Total Contributions" columns represent those plans where Health Plans and Hospitals were listed in the plans' Forms 5500 as providing more than 5% of the total contributions for the plan years listed. The last column lists the expiration dates of the collective bargaining agreements to which the plans are subject. There have been no significant changes that affect the comparability of 2016 and 2015 employer expense.

Pension Fund	EIN-PN	Pension Protection Act Zone Status 2016	Pension Protection Act Zone Status 2015	FIP/RP Status Pending / Implemented	(in millions) Health Plans' and Hospitals' Contributions December 31, 2016	(in millions) Health Plans' and Hospitals' Contributions December 31, 2015	Surcharge Imposed	Health Plans' and Hospitals' Contributions to Plan Exceeded More Than 5% of Total Contributions [1] 2015	Health Plans' and Hospitals' Contributions to Plan Exceeded More Than 5% of Total Contributions [1] 2014	Expiration Date of Collective Bargaining Agreement
IUOE Stationary Engineers Local 39 Pension Fund	946118939 -001	Green	Green	N/A	$ 11	$ 10	No	Yes	Yes	9/17/2018
Southern California United Food and Commercial Workers Unions and Drug Employers Pension Fund	516029925 -001	Red	Red	Implemented	5	5	No	Yes	Yes	2/1/2020
Oregon Retail Employees Pension Trust[2]	936074377 -001	Red	Red	Implemented	4	4	No	Yes	Yes	9/30/2018-10/31/2018
Carpenters Pension Trust Fund for Northern California	946050970 -001	Red	Red	Implemented	7	6	No	No	No	6/30/2019
Other	Various	Green	Green		14	13		No	No	9/30/2017-12/31/2020
Other	Various	Yellow	Yellow		4	3		No	No	6/30/2017-6/30/2019
Total Expense					$ 45	$ 41				

(1) Forms 5500 information was available for all plan years ended in 2015. The majority of plans have a plan year end of December 31.

(2) Includes UFCW Local 555 Pharmacy Techs and Radiologists expiring September 30, 2018 and October 31, 2018, respectively.

(14) Postretirement Benefits Other than Pensions

(a) Defined Benefit Plan

Certain employees may become eligible for postretirement health care and life insurance benefits while working for Health Plans and Hospitals. Benefits available to retirees, through both affiliated and unaffiliated provider networks, vary by employee group. Postretirement health care benefits available to retirees include subsidized Medicare premiums, medical and prescription drug benefits, dental benefits, and vision benefits.

In January 2015, Health Plans and Hospitals modified postretirement health care benefits for certain union represented employees. Under the terms of the agreement, cost sharing will increase for plan participants and future employer-paid monthly premiums will be fixed. The impact of the agreement resulted in a negative plan amendment and a reduction in liabilities of $477 million.

At December 31, the accrued liability for postretirement benefits was as follows (in millions):

	2016	2015
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 5,503	$ 7,193
Service cost	156	192
Interest cost	235	256
Plan amendments	7	(756)
Benefits paid or provided	(133)	(136)
Net actuarial gain	(332)	(1,246)
Benefit obligation at end of year	$ 5,436	$ 5,503
Change in plan assets:		
Fair value of plan assets at beginning of year	$ 1,365	$ 400
Actual return on plan assets	130	(35)
Contributions	1,733	1,136
Benefits paid or provided	(133)	(136)
Fair value of plan assets at end of year	$ 3,095	$ 1,365
Funded status	$ (2,341)	$ (4,138)
Amounts recognized in the balance sheet consist of:		
Noncurrent assets	$ —	$ —
Current liabilities	—	—
Pension and other retirement liabilities	(2,341)	(4,138)
	$ (2,341)	$ (4,138)
Amounts recognized in net worth:		
Net actuarial loss	$ 2,201	$ 2,671
Prior service credit	(2,286)	(2,724)
	$ (85)	$ (53)

The measurement date used to determine postretirement benefits valuations was December 31.

For the years ended December 31, postretirement benefits expense was as follows (in millions):

	2016	2015
Service cost	$ 156	$ 192
Interest cost	235	256
Expected return on plan assets	(100)	(28)
Amortization of net actuarial loss	108	224
Amortization of prior service credit	(431)	(439)
Postretirement benefits expense	(32)	205
Other changes in plan assets and benefit obligations recognized in net worth:		
Net actuarial gain	(362)	(1,183)
Prior service cost (credit)	7	(756)
Amortization of net actuarial loss	(108)	(224)
Amortization of prior service credit	431	439
Total recognized in net worth	(32)	(1,724)
Total recognized in net periodic benefit cost and net worth	$ (64)	$ (1,519)

During 2017, $104 million and $(429) million in estimated net actuarial loss and prior service credit, respectively, will be amortized from net worth into postretirement benefits expense.

During 2016, the employer contributions and benefits paid or provided were $1,733 million and $133 million, respectively. During 2015, the employer contributions and benefits paid or provided were $1,136 million and $136 million, respectively. During 2016 and 2015, there were no participant contributions from active employees.

Actuarial assumptions used were as follows:

	2016	2015
Weighted average discount rate used for calculating non-union plan postretirement benefits expense from January 1 to December 31	4.75%	4.35%
Weighted average discount rate for calculating union plan postretirement benefits expense from January 1 to January 24	4.75%	4.35%
Weighted average discount rate for calculating union plan postretirement benefits expense from January 25 to December 31	4.75%	3.90%
Weighted average discount rate for calculating December 31 accumulated postretirement benefit obligation	4.45%	4.75%
Expected long-term rate of return on plan assets for calculating benefits expense	7.00%	7.00%

The following were the assumed health care cost trend rates used to determine the December 31, 2016 and 2015 benefit obligation and postretirement benefits expense for the years ended December 31, 2016 and 2015:

	Basic medical Pre-65/Post-65	Prescription drug Pre-65/Post-65	Medicare Part D	Dental	Medicare Part A&B	Medicare Part C	Supplemental medical Pre-65/Post-65
Initial trend rate - 2015	5.50% / 5.25%	8.00% / 8.00%	4.00%	4.50%	5.25%	2.00%	5.50% / 5.25%
Initial trend rate - 2016	5.50% / 5.25%	7.00% / 7.00%	4.00%	4.50%	5.25%	3.25%	5.50% / 5.25%
Ultimate trend rate	4.50% / 4.50%	4.50% / 4.50%	4.50%	4.50%	4.50%	4.50%	4.50% / 4.50%
First year at ultimate trend rate	2026 / 2022	2025 / 2025	2026	2015	2022	2018	2026 / 2022

A 1% increase in the health care medical trend rate would increase the benefit obligation by $701 million and the service cost plus interest by $52 million. A decrease of 1% in the health care medical trend rate would decrease the benefit obligation by $574 million and the service cost plus interest by $41 million.

The following benefit payments, which reflect expected future service, are expected to be paid or provided (in millions):

2017	$ 155
2018	166
2019	182
2020	200
2021	220
2022 - 2026	1,420

Explanation of Investment Strategies and Policies

A total return investment approach is employed for the retirement benefit trust whereby the assets are invested in various asset classes to maximize the long-term return of plan assets for a prudent level of risk. The intent of this strategy is to minimize plan expenses by outperforming plan liabilities over the long run. Risk tolerance is established through consideration of plan liabilities, plan funded status, and corporate financial condition. The investment portfolio will consist over time of a varying but diversified blend of equity, fixed-income, and alternative investments. Diversification includes such factors as geographic location, equity capitalization size and style, placement in the capital structure, and security type. Investment risk is measured and monitored on an ongoing basis through annual liability measurements, periodic asset/liability studies, and quarterly investment portfolio reviews. The retirement benefit trust investment policy has restrictions relating to credit quality, industry/sector concentration, duration, concentration of ownership, and use of derivatives.

Capital Market Assumption Methodology

To determine the long-term rate of return assumption for plan assets, management incorporates historical relationships among the various asset classes and subclasses to be accessed over the investment horizon. Management's intent is to maximize portfolio efficiency. This will be accomplished by seeking the highest returns prudently available among the available asset classes. Overall portfolio volatility is managed through diversification among asset classes. Current market factors such as inflation and interest rates are evaluated before long-term capital market assumptions are determined. From time to time, management reviews its long-term investment strategy and reconciles that strategy with the long-term liabilities of the Plan. This asset-liability study produces a range of expected returns over medium and long-term time periods. Those intermediate and long-term investment projections form the basis for the expected long-term rate of return on assets.

At December 31, 2016, the estimated fair value of retirement benefit trust assets by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
Assets:				
Cash and cash equivalents	$ —	$ 201	$ —	$ 201
Alternative investments:				
Absolute return	—	949	206	1,155
Risk parity	—	851	886	1,737
Other	—	2	—	2
Total assets	$ —	$ 2,003	$ 1,092	$ 3,095

At December 31, 2015, the estimated fair value of retirement benefit trust assets by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
Assets:				
Cash and cash equivalents	$ —	$ 650	$ —	$ 650
Alternative investments:				
Risk parity	—	375	340	715
Total assets	$ —	$ 1,025	$ 340	$ 1,365

At December 31, reconciliations of alternative investments with fair value measurements using significant unobservable inputs (level 3) were as follows (in millions):

	2016	2015
Beginning balance	$ 340	$ —
Transfers into level 3	—	—
Changes related to actual return on plan assets	56	(10)
Purchases, sales, and settlements - net	696	350
Ending balance	$ 1,092	$ 340
Total year-to-date net gains (losses) related to assets held at end of period	$ 56	$ (10)

The target asset allocation and expected long-term rate of return on assets (ELTRA) for calculating postretirement benefits expense were as follows:

	2016 and 2015 target range	2016 and 2015 ELTRA
Alternative investments	100%	7.00%
Total	100%	7.00%

Absolute return and risk parity investments include redemption restrictions. Absolute return and risk parity investments require 10 to 90 day written notice of intent to withdraw and are often subject to the approval and capital requirements of the fund manager. At December 31, 2016, absolute return and risk parity investments of $429 million are subject to lock-up periods of up to 3 years.

(b) Multi-Employer Plans

Health Plans and Hospitals participate in multi-employer union-administered retiree medical health and welfare plans that provide benefits to some union employees. Benefits for retirees under these plans are negotiated as part of the collective bargaining process. For the years ended December 31, 2016 and 2015, Health Plans' and Hospitals' employer expense for both current and retiree benefits was $81 million and $77 million, respectively.

(15) Physicians' Retirement Plan

Kaiser Foundation Health Plan, Inc. provides defined retirement benefits for physicians associated with certain Medical Groups. Benefits are determined based on the length of service and level of compensation of each participant. The plan is unfunded and is not subject to the Employee Retirement Income Security Act.

At December 31, the accrued liability for physicians' retirement plan was as follows (in millions):

	2016	2015
Change in projected benefit obligation:		
Physicians' retirement plan liability at January 1	$ 5,901	$ 6,078
Service cost	317	327
Interest cost	283	258
Net actuarial loss (gain)	414	(608)
Benefits paid	(164)	(154)
Physicians' retirement plan liability at December 31	$ 6,751	$ 5,901
Accumulated benefit obligation at end of year	$ 5,306	$ 4,624
Change in plan assets:		
Fair value of plan assets at the beginning of year	$ —	$ —
Company contributions	164	154
Benefits paid	(164)	(154)
Fair value of plan assets at end of year	$ —	$ —
Funded status	$ (6,751)	$ (5,901)
Amounts recognized in the balance sheet consist of:		
Noncurrent assets	$ —	$ —
Current liabilities	(185)	(171)
Noncurrent liability	(6,566)	(5,730)
	$ (6,751)	$ (5,901)
Amounts recognized in net worth:		
Net actuarial loss	$ 1,733	$ 1,373

The measurement date used to determine physicians' retirement valuation was December 31.

A portion of the investments of Health Plans has been designated by management for the liabilities of the physicians' retirement plan. These investments are not held in trust or otherwise legally segregated and are not restricted even though it has been intended that these assets be used to pay the obligations of the physicians' retirement plan.

For purposes of the physicians' retirement plan expense, the expected return on assets is the portion of investment income that represents the expected return on the investments designated for the physicians' retirement plan. This amount is recorded as a reduction in the expense for the physicians' retirement plan and is excluded from investment income - net, as described below and in the *Summary of Significant Accounting Policies - Investments* note.

For the years ended December 31, physicians' retirement plan provision was as follows (in millions):

	2016	2015
Service cost	$ 317	$ 327
Interest cost	283	258
Amortization of net actuarial loss	54	92
Total benefit expense	654	677
Expected return on assets - investment income included in operating expenses	(427)	(435)
Net benefit expense	227	242
Other changes in projected benefit obligations recognized in net worth		
Net actuarial loss (gain)	414	(608)
Amortization of net actuarial loss	(54)	(92)
Total recognized in net worth	360	(700)
Total recognized in net periodic benefit cost and net worth	$ 587	$ (458)

During 2017, $70 million in estimated net actuarial loss will be amortized from net worth into net benefit expense.

Actuarial assumptions used were as follows:

	2016	2015
Weighted average discount rate at January 1 for calculating benefit expense	4.80%	4.30%
Weighted average discount rate for calculating December 31 PBO	4.55%	4.80%
Weighted average salary scale for calculating pension expense	4.40%	4.40%
Weighted average salary scale for calculating December 31 PBO	4.40%	4.40%
Expected long-term rate of return on designated investments for calculating benefit expense	7.25%	7.25%

The following benefit payments, which reflect expected future service, are expected to be paid (in millions):

2017	$	185
2018		203
2019		223
2020		243
2021		265
2022 - 2026		1,618

(16) Commitments and Contingencies

(a) Lease and Purchase Commitments

Health Plans and Hospitals lease primarily office space, medical facilities, and equipment under various leases that expire through 2048. Certain leases contain rent escalation clauses and renewal options for additional periods.

At December 31, 2016, minimum commitments under noncancelable leases extending beyond one year were as follows (in millions):

2017	$	316
2018		293
2019		224
2020		192
2021		157
Thereafter		406
Total	$	1,588

Minimum payments above have not been reduced by minimum sublease rentals of $2 million due in the future under noncancelable subleases.

For the years ended December 31, 2016 and 2015, total lease expense for all leases was $464 million and $459 million, respectively.

Health Plans and Hospitals have entered into long-term agreements that require certain minimum purchases of goods and services. These commitments are at levels that are consistent with normal business requirements. Health Plans has committed to directing most of its purchasing volume for selected products through an outside agency and has committed to at least $1 billion in purchasing per annum through March 31, 2017. During 2016 and 2015, Health Plans' total purchases through this outside agency exceeded $1 billion. Should the $1 billion level not be achieved, financial penalties would be assessed at an established percentage of any shortfalls. In management's judgment, there is a remote probability of material financial penalties under this contract.

At December 31, 2016, minimum purchase commitments, excluding contracts that count towards the $1 billion per annum commitment noted above, extending beyond one year were as follows (in millions):

2017	$	361
2018		236
2019		176
2020		65
2021		8
Thereafter		16
Total	$	862

During 2016 and 2015, Health Plans' and Hospitals' total purchases under contracts with minimum purchase commitments, excluding those purchases which count towards the $1 billion per annum commitment noted above, were $552 million and $542 million, respectively.

(b) Renewable Energy Contracts

Hospitals has entered into 20 year renewable energy contracts to reduce the financial risk of unexpected increases in utility prices and help achieve its renewable energy goals. Under the renewable energy contracts, Hospitals will net settle with the counterparty based on 100% of the output of two renewable energy sites and also realize renewable energy credits from the production of energy from wind and solar sites. The wind site started its production in December 2015 and the solar site began its production in May 2016. To the extent that the price of electrical energy varies from the fixed amounts in the contracts, Hospitals will pay more or less than the current value of electrical energy over the term of the contracts. Management cannot reasonably estimate the future financial impact of these contracts as they are subject to market fluctuations in energy prices and to the actual production volume of the sites. In addition, Health Plans and Hospitals have entered into multiple on-site renewable energy contracts ranging between 10 and 20 years that are recorded as either contingent operating leases or purchase agreements.

(c) Surety Instruments and Standby Letters of Credit

In the normal course of business, Health Plans and Hospitals contract to perform certain financial obligations that require a guarantee from a third party. This guarantee creates a contingent liability to the entity that provides that guarantee. At December 31, 2016 and 2015, Health Plans and Hospitals had entered into surety instruments and standby letters of credit that totaled $87 million and $81 million, respectively.

Health Plan, Inc. and Hospitals also guarantee payment of workers' compensation liabilities of certain Medical Groups under self-insurance programs. The majority of such liabilities are recorded as other long-term liabilities of Health Plan, Inc., as payment is provided for under the applicable medical service agreements. In addition to amounts accrued, at December 31, 2016 and 2015, pursuant to such

guarantees, Health Plan, Inc. and Hospitals are contingently liable for approximately $180 million and $200 million, respectively, of certain Medical Groups' self-insured workers' compensation liabilities.

(d) Regulatory

Health Plans is required to periodically file financial statements with regulatory agencies in accordance with statutory accounting and reporting practices. Health Plans must comply with the various states' minimum regulatory net worth requirements generally under the regulation of the California Department of Managed Health Care and various state departments of insurance. Such requirements are generally based on tangible net equity or risk-based capital, and for California are calculated on the basis of combined net worth of Health Plans and Hospitals. At December 31, 2016 and 2015, the regulatory net worth, so defined, exceeded the aggregate regulatory minimum requirements by approximately $25 billion and $23 billion, respectively.

Health Plans' regulated subsidiaries maintain investments in various states where they are licensed. At December 31, 2016 and 2015, $6 million and $5 million, respectively, in securities were held to satisfy various state regulatory requirements.

Health Plans and Hospitals are subject to numerous and complex laws and regulations of federal, state, and local governments, and accreditation requirements. Compliance with such laws, regulations, and accreditation requirements can be subject to retrospective review and interpretation, as well as regulatory actions. These laws and regulations include, but are not necessarily limited to, requirements of tax exemption, government reimbursement, government program participation, privacy and security, false claims, anti-kickback, accreditation, healthcare reform, controlled substances, facilities, and professional licensure. In recent years, government activity has increased with respect to compliance and enforcement actions.

In the ordinary course of business operations, Health Plans and Hospitals are subject to periodic reviews, investigations, and audits by various federal, state, and local regulatory agencies and accreditation agencies, including, without limitation, CMS, Department of Managed Health Care, Office of Personnel Management, Occupational Safety and Health Administration, Drug Enforcement Administration, State Boards of Pharmacy, Food and Drug Administration, IRS, National Committee for Quality Assurance, and state departments of insurance.

Health Plans' and Hospitals' compliance with the wide variety of rules and regulations and accreditation requirements applicable to their business may result in certain remediation activities and regulatory fines and penalties, which could be substantial. Where appropriate, reserves have been established for such sanctions. While management believes these reserves are adequate, the outcome of legal and regulatory matters is inherently uncertain, and it is possible that one or more of the legal or regulatory matters currently pending or threatened could have a material adverse effect on the combined financial position or results of operations.

(e) Litigation

Health Plans and Hospitals are involved in lawsuits and various governmental investigations, audits, reviews, and administrative proceedings arising, for the most part, in the ordinary course of business operations. Lawsuits have been brought under a wide range of laws and include, but are not limited to, business disputes, employment and retaliation claims, claims alleging professional liability, improper disclosure of personal information, labor disputes, administrative regulations, the False Claims Act, information privacy and HIPAA laws, mental health parity laws, and consumer protection laws. In addition, Health Plans indemnifies the Medical Groups against various claims, including professional liability claims.

Health Plans and Hospitals record reserves for legal proceedings and regulatory matters where available information indicates that at the date of the combined financial statements a loss is probable and the amount can be reasonably estimated. While such reserves reflect management's best estimate of the probable loss for such matters, Health Plans' and Hospitals' recorded amounts may differ materially from the actual amount of any such losses.

In September 2015, a lawsuit was filed seeking to have the State of California impose the gross premiums tax on Health Plan, Inc. In the opinion of management, strong defenses exist regarding this claim. However, an unfavorable outcome could have a material adverse effect. No reserves have been provided related to this lawsuit.

Pursuant to a civil subpoena, Health Plans and Hospitals have provided documents and information to the Department of Justice and Department of Health and Human Services - Office of Inspector General relating to Medicare Part C risk adjustment practices, policies, and programs. This matter could result in a False Claims Act litigation, in which an unfavorable outcome could have a material adverse effect. No reserves have been provided related to this matter.

In the opinion of management, based upon current facts and circumstances, the resolution of these matters is not expected to have a material adverse effect on the combined financial position or combined results of operations of Health Plans and Hospitals. The outcome of litigation and other legal and regulatory matters is inherently uncertain, however, and it is possible that one or more of the legal or regulatory matters currently pending or threatened could have a material adverse effect.