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

Combined Financial Statements and
Additional Information

For the three months ended March 31, 2017 and 2016

(Unaudited)

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

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

Combined Balance Sheets

March 31, 2017 and December 31, 2016

(In millions)

Assets	2017	2016
Current assets:		
Cash and cash equivalents	$ 446	$ 434
Current investments	7,494	8,677
Securities lending collateral	1,062	631
Broker receivables	679	767
Due from associated medical groups	78	12
Accounts receivable - net	2,337	2,030
Inventories and other current assets	1,605	1,357
Total current assets	13,701	13,908
Noncurrent investments	28,766	25,756
Land, buildings, equipment, and software - net	25,018	24,342
Goodwill	291	—
Other acquired intangible assets	316	—
Other long-term assets	628	607
Total assets	$ 68,720	$ 64,613
Liabilities and Net Worth		
Current liabilities:		
Accounts payable and accrued expenses	$ 3,739	$ 3,852
Medical claims payable	2,282	1,862
Due to associated medical groups	830	862
Payroll and related charges	1,859	1,828
Medicare payments received in advance	1,324	—
Securities lending payable	1,062	631
Broker payables	1,329	849
Long-term debt subject to short-term remarketing arrangements - net	785	785
Other current debt	1,756	1,904
Other current liabilities	2,421	2,102
Total current liabilities	17,387	14,675
Long-term debt	4,757	4,754
Physicians' retirement plan liability	6,675	6,566
Pension and other retirement liabilities	8,278	9,148
Other long-term liabilities	2,501	2,380
Total liabilities	39,598	37,523
Net worth	29,122	27,090
Total liabilities and net worth	$ 68,720	$ 64,613

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

Three months ended March 31, 2017 and 2016

(In millions)

	2017	2016
Revenues:		
Members' dues	$ 12,329	$ 11,016
Medicare	4,200	3,825
Copays, deductibles, fees, and other	1,581	1,457
Total operating revenues	18,110	16,298
Expenses:		
Medical services	8,509	7,608
Hospital services	4,523	4,146
Outpatient pharmacy and optical services	2,005	1,841
Other benefit costs	1,157	1,013
Total medical and hospital services	16,194	14,608
Health Plan administration	880	989
Total operating expenses	17,074	15,597
Operating income	1,036	701
Other income and expense:		
Investment income (loss) - net	582	(157)
Interest expense	(55)	(40)
Total other income and expense	527	(197)
Net income	1,563	504
Change in pension and other retirement liability charges	47	(8)
Change in net unrealized gains on investments	422	286
Change in noncontrolling interest	—	3
Change in net worth	2,032	785
Net worth at beginning of year	27,090	24,897
Net worth at end of period	$ 29,122	$ 25,682

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 (in millions)

Combined Statements of Cash Flows

Three months ended March 31, 2017 and 2016
(In millions)

	2017	2016
Cash by from operating activities:		
Net income	$ 1,563	$ 504
Adjustments to reconcile net income to net cash provided by from operating activities:		
Depreciation and software amortization	608	557
Other amortization	(12)	(18)
Loss (gain) recognized on investments - net	(487)	191
Loss on land, buildings, equipment, and software - net	24	4
Changes in assets and liabilities:		
Accounts receivable - net	(115)	(289)
Due from associated medical groups	(66)	(110)
Other assets	(179)	(402)
Accounts payable and accrued expenses	(97)	353
Medical claims payable	143	64
Due to associated medical groups	(123)	46
Payroll and related charges	(44)	51
Medicare payments received in advance	1,324	—
Pension and other retirement liabilities	(950)	289
Other liabilities	319	214
Net cash provided by operating activities	1,908	1,454
Cash by from investing activities:		
Additions to land, buildings, equipment, and software	(767)	(669)
Proceeds from sales of land, buildings, and equipment	1	1
Proceeds from investments	11,996	9,594
Investment purchases	(11,845)	(10,291)
Increase in securities lending collateral	(431)	(10)
Broker receivables / payables	562	(201)
Issuance of notes receivable	(29)	(32)
Prepayment and repayment of notes receivable	28	22
Physicians' retirement plan liability	126	117
Cash paid for acquisition, net of cash assumed	(1,686)	—
Other investing	(160)	(9)
Net cash used in investing activities	(2,205)	(1,478)
Cash by from financing activities:		
Issuance of debt	1,099	886
Prepayment and repayment of debt	(1,221)	(884)
Increase in securities lending payable	431	10
Change in noncontrolling interest	—	3
Net cash provided from financing activities	309	15
Net change in cash and cash equivalents	12	(9)
Cash and cash equivalents at beginning of year	434	210
Cash and cash equivalents at end of year	$ 446	$ 201
Supplemental cash flows disclosure:		
Cash paid for interest - net of capitalized amounts	$ 23	$ 32

(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 March 31, 2017 and December 31, 2016 was 11.8 million and 10.7 million, respectively. At March 31, 2017 and December 31, 2016, the percentage of enrolled membership in California was approximately 73% and 77%, respectively. The principal operating subsidiary of Kaiser Foundation Hospitals is Kaiser Hospital Asset Management, Inc. (KHAM). The principal direct and indirect 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 Foundation Health Plan of Washington
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 March 31, 2017 and December 31, 2016, the percentage of Health Plans' and Hospitals' total labor force covered under collective bargaining agreements was approximately 70% and 71%, respectively. At March 31, 2017, approximately 10% of the workforce was covered under collective bargaining agreements that were scheduled to expire within one year. At March 31, 2017, none of the workforce was working under an expired 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.

(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 May 15, 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) Accounts Receivable - net

Accounts receivable – net are comprised of members' dues, Medicare receivables, patient receivables and other receivables. Health Plans and Hospitals provides an allowance for potential uncollectible accounts receivable. The allowances for bad debt are estimated based on the aging of accounts receivable, historical collection experience, and other economic factors.

(g) Inventory

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

(h) 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 40 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.

(i) Goodwill and Other Acquired Intangible Assets

Goodwill and other acquired intangible assets arise from acquisition related activity. Goodwill represents the excess of the purchase price over the fair value of net assets acquired when accounted for using the acquisition method of accounting. Goodwill is required to be tested for impairment at least annually, or sooner, whenever events or circumstances indicate that the asset may be impaired.

Other acquired intangible assets are recognized at fair value on the date of purchase and are amortized on a straight-line or accelerated basis over periods from 4 to 16 years. These intangible assets are subject to impairment tests when events or circumstances indicate that these assets may be impaired.

(j) 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 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.

(k) 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.

(l) 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.

(m) 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 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 March 31, 2017 and December 31, 2016, premium deficiency reserves were $36 million and $16 million, respectively. Given the inherent variability of such estimates, the actual liability could differ significantly from the calculated amount.

(n) 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.

(o) 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 three months ended March 31, 2017 and 2016, the amount of premiums written by Health Plans subject to the retrospective rating feature were $268 million and $235 million, respectively. During the three months ended March 31, 2017 and 2016, revenue derived under these contracts was 2.2% and 2.1%, respectively, of total

members' dues. During the three months ended March 31, 2017 and 2016, retrospective dues reductions derived under these contracts were $6 million and $3 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 three months ended March 31, 2017 and 2016, dues subject to these risk adjustment arrangements comprise 8.2% and 8.7%, respectively, of total members' dues. During the three months ended March 31, 2017 and 2016, $36 million and $37 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 the three months ended March 31, 2017 and 2016, revenues related to these arrangements were $336 million and $365 million, respectively.

(p) 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 change will result in a reduction in pension and other postretirement benefits expense of approximately $280 million during 2017.

(q) 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.

(r) Income Taxes

Health Plans and Hospitals are not-for-profit corporations exempt from income taxes under Internal Revenue Code Section 501(a) as organizations described in section 501(c)(3) and the laws of the states in which they operate. Accordingly, Health Plans and Hospitals are generally not subject to federal or state income taxes. Health Plans and Hospitals are subject to income taxes on unrelated business income. A limited number of Health Plans' and Hospitals' subsidiaries are for profit entities and are subject to income taxes. For the three months ended March 31, 2017 and 2016, no significant income tax provision has been recorded.

(s) 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; goodwill and intangible assets; 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.

(t) The PPACA Reinsurance, Risk Adjustment, and Risk Corridors Programs

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

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 three months ended March 31,

2017 and 2016, Health Plans recorded $76 million and $24 million, respectively, in net revenue reductions related to the Risk Adjustment Program.

The Risk Corridors Program was temporary and was terminated in 2016. This program provided for gains and losses on the individual and small group market plans. For both the three months ended March 31, 2017 and 2016, Health Plans did not record revenue adjustments related to the Risk Corridors Program.

The Reinsurance Program was temporary and was terminated in 2016. This program provided for partial reimbursement of certain high cost claims for non-grandfathered individual members. As described in the *Summary of Significant Accounting Policies - Medical Claims Payable* note, certain amounts have been recorded in 2017 and 2016 as expected claims reimbursements under this program. For the three months ended March 31, 2017 and 2016, Health Plans recorded $2 million and $12 million, respectively, for estimated recoveries from the Reinsurance Program. For the three months ended March 31, 2017 and 2016, Health Plans recorded $0 million and $55 million, respectively, of Reinsurance fees.

Net receivables (payables) for PPACA Reinsurance recoveries, Risk Adjustment settlements, and Risk Corridors settlements were as follows (in millions):

	At March 31, 2017	At December 31, 2016
Risk Adjustment settlements	$ (764)	$ (654)
Risk Corridors settlements	—	1
Reinsurance recoveries	137	150
Total	$ (627)	$ (503)

(u) 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 was adopted in 2017. The adoption of this standard did not have a significant effect on the combined financial statements and related disclosures.

In May 2015, the FASB issued ASU No. 2015-07 *Fair Value Measurement (Topic 820), Disclosures for Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*. The amendments in this update remove the requirement to categorize within fair value hierarchy all investments for which fair value is measured using the net asset value per share practical expedient. The new standard was adopted in 2017. Disclosures have been updated as required by the standard.

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 was adopted by Health Plans and Hospitals in 2017. The standard requires the application of the prospective transition method. The adoption of this standard did not have a significant effect on the combined financial statements and related disclosures.

In September 2015, the FASB issued ASU No. 2015-16 *Business Combinations (Topic 805) – Simplifying the Accounting for Measurement-Period Adjustments*. The standard simplifies the accounting for adjustments made to provisional amounts recognized in a business combination, eliminating the requirement to retrospectively account for those adjustments. The new standard was adopted by Health Plans and Hospitals in 2017. The adoption of this standard did not 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 was adopted by Health Plans and Hospitals in 2017. The standard requires the use of the prospective transition method. The adoption of this standard did not 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.

In January 2017, the FASB issued ASU No. 2017-04 *Intangibles - Goodwill and Other (Topic 350), Simplifying the Test for Goodwill Impairment.* The amendments in this update eliminate Step 2 from the goodwill impairment test in an effort to simplify the subsequent measurement of goodwill. The new standard is effective for Health Plans and Hospitals on January 1, 2022. Early application is permitted. Management is evaluating the effect that ASU No. 2017-04 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 February 2017, the FASB issued ASU No. 2017-05 *Other Income - Gains and Losses from the Derecognition of Nonfinancial Assets (Subtopic 610-20).* The amendments in this update clarify the scope of guidance on nonfinancial asset derecognition as well as the accounting for partial sales of nonfinancial assets. The new standard is effective for Health Plans and Hospitals on January 1, 2018. Early application is permitted, but the amendments in this update must be applied at the same time as the amendments in ASU No. 2014-09. Management is evaluating the effect that ASU No. 2017-05 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 March 2017, the FASB issued ASU No. 2017-07 *Compensation - Retirement Benefits (Topic 715), Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. The amendments in this update require that an employer disaggregate the service cost component from the other components of net benefit cost and provide explicit guidance on how to present the service cost component and the other components of net benefit cost in the income statement. 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. The impact of adoption will result in the non-service cost components of pension and postretirement benefit costs, previously classified as an operating expense, being reported as other income and expense.

In March 2017, the FASB issued ASU No. 2017-08 *Receivables - Nonrefundable Fees and Other Costs (Subtopic 310-20), Premium Amortization on Purchased Callable Debt Securities.* The amendments in this update require the premium for certain callable debt securities to be amortized to the earliest call date. The new standard is effective for Health Plans and Hospitals on January 1, 2020. Early application is permitted. The standard requires the use of the modified retrospective transition method. Management is evaluating the effect that ASU No. 2017-05 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, KFHPW Holdings (Holdings), a subsidiary of Health Plan Inc., acquired and became the sole corporate member of Group Health Cooperative (GHC), a Washington nonprofit corporation (the "Acquisition"). After closing of the Acquisition, GHC will remain the sole shareholder of Group Health Options, Inc. (GHO), a Washington for-profit corporation. Following the Acquisition, GHC was renamed "Kaiser Foundation Health Plan of Washington", and GHO was renamed "Kaiser Foundation Health Plan of Washington Options, Inc." (Kaiser Foundation Health Plan of Washington and its subsidiaries are collectively referred to herein as Washington Health Plans)

Washington Health Plans 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, Washington Health Plans provides certain health care services on a fee for service basis to both members and nonmembers. 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 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 Washington Health Plans, and also states that $800 million in community benefit contributions is expected to be made over the same period. During the period ended March 31, 2017, $17 million in capital and other investments were made. At March 31, 2017, $983 million of remaining capital and other investment commitments are required to be made relating to the Acquisition.

Prior to the Acquisition, Group Health Permanente, P.C. (GHP), which is an independent medical group, provided physician and certain other medical services exclusively to Washington Health Plans' members. As part of the successful completion of the Acquisition, Holdings and GHP entered into agreements to continue that arrangement following closing of the Acquisition, including payments to GHP of up to $200 million, recognized primarily as operating expenses and intangible assets. Following the Acquisition, GHP was renamed "Washington Permanente Medical Group, P.C.".

The following table summarizes the fair value measurement of the assets acquired and liabilities assumed at the date of the acquisition (in millions):

Current investments	$	274
Accounts receivable		192
Other current assets		179
Noncurrent investments		777
Land, buildings, equipment, and software		698
Goodwill		291
Other acquired intangible assets		251
Other long-term assets		26
Medical claims payable		(277)
Other current liabilities		(438)
Pension and other retirement liabilities		(110)
Other long-term liabilities		(63)
Total purchase price	$	1,800

Goodwill represents the excess of the purchase price over the fair value of net tangible and intangible assets acquired and primarily relates to expected contributions of Washington Health Plans to the overall corporate strategy.

For the three months ended March 31, 2017, acquisition related costs of $12 million were recognized in operating expenses.

The results of operations of Washington Health Plans since the acquisition date of February 1, 2017, are included in Health Plans and Hospitals combined financial statements and include $709 million of revenue and $18 million of operating income.

The following table summarizes Health Plans' and Hospitals' unaudited pro forma results of operations as if the Acquisition had occurred on January 1, 2016 (in millions):

	Three months ended March 31,	
	2017	**2016**
Revenues	$ 18,456	$ 17,277
Operating Income	$ 1,085	$ 739

The pro forma disclosures in the table above include adjustments primarily for amortization of other acquired intangible assets, depreciation of the adjusted fair value of buildings and equipment, and other nonrecurring costs related to the acquisition to reflect results that are more representative of the combined results of the transactions, as if the Acquisition had occurred on January 1, 2016. This pro forma information is presented for illustrative purposes only and may not be indicative of the results of operation that would have actually occurred.

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 both March 31, 2017 and December 31, 2016, the carrying amount of long-term debt totaled $5.6 billion. At both March 31, 2017 and December 31, 2016, the estimated fair value of long-term debt was approximately $5.7 billion, respectively.

At March 31, 2017 and December 31, 2016, 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 March 31, 2017, 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	$ 18	$ —	$ —	$ 18
Debt securities issued by the U.S. government	—	2,052	—	2,052
Debt securities issued by U.S. government agencies and corporations	—	72	—	72
Debt securities issued by U.S. states and political subdivisions of states	—	77	—	77
Foreign government debt securities	—	95	—	95
U.S. corporate debt securities	—	2,038	—	2,038
Foreign corporate debt securities	—	883	—	883
U.S. agency mortgage-backed securities	—	740	—	740
Non-U.S. agency mortgage-backed securities	—	165	—	165
Other asset-backed securities	—	617	—	617
Short-term investment funds	—	735	—	735
Other	—	2	—	2
Total	$ 18	$ 7,476	$ —	$ 7,494

At March 31, 2017, 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	$ 4,491	$ 179	$ 5	$ 4,675
Foreign equity securities	2,420	1,476	—	3,896
Global equity funds	—	494	—	494
Debt securities issued by the U.S. government	—	1,312	—	1,312
Debt securities issued by U.S. government agencies and corporations	—	77	—	77
Debt securities issued by U.S. states and political subdivisions of states	—	186	—	186
Foreign government debt securities	—	1,219	—	1,219
U.S. corporate debt securities	—	3,963	—	3,963
Foreign corporate debt securities	—	1,562	—	1,562
U.S. agency mortgage-backed securities	—	635	—	635
Non-U.S. agency mortgage-backed securities	—	242	8	250
Other asset-backed securities	—	269	—	269
Short-term investment funds	—	2,197	—	2,197
Other	442	542	1	985
	$ 7,353	$ 14,353	$ 14	21,720
Alternative investments:				
Absolute return				2,102
Private equity				4,247
Risk parity				697
Total				$ 28,766

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
	$ 6,577	$ 12,329	$ 9	18,915
Alternative investments:				
Absolute return				2,076
Private equity				4,089
Risk parity				676
Total				$ 25,756

At March 31, 2017, 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	$ 3,879	$ 814	$ —	$ 4,693
Foreign equity securities	3,144	752	—	3,896
Global equity funds	362	132	—	494
Debt securities issued by the U.S. government	3,349	15	—	3,364
Debt securities issued by U.S. government agencies and corporations	145	4	—	149
Debt securities issued by U.S. states and political subdivisions of states	237	26	—	263
Foreign government debt securities	1,219	95	—	1,314
U.S. corporate debt securities	5,752	249	—	6,001
Foreign corporate debt securities	2,340	105	—	2,445
U.S. agency mortgage-backed securities	1,363	12	—	1,375
Non-U.S. agency mortgage-backed securities	404	11	—	415
Other asset-backed securities	871	15	—	886
Short-term investment funds	2,932	—	—	2,932
Other	965	22	—	987
Total	$ 26,962	$ 2,252	$ —	$ 29,214

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

Available-for-sale debt securities by contractual maturity and mortgage-backed and other asset-backed debt securities were as follows (in millions):

	At March 31, 2017		At December 31, 2016	
	Amortized cost	Fair value	Amortized cost	Fair value
Due in one year or less	$ 4,263	$ 4,273	$ 2,356	$ 2,362
Due after one year through five years	6,284	6,395	7,604	7,702
Due after five years through ten years	2,963	3,087	2,563	2,671
Due after ten years	3,429	3,700	3,313	3,557
U.S. agency mortgage-backed securities	1,363	1,375	1,338	1,349
Non-U.S. agency mortgage-backed securities	404	415	451	459
Other asset-backed securities	871	886	949	964
Total	$ 19,577	$ 20,131	$ 18,574	$ 19,064

For the three months ended March 31, 2017, the reconciliation of investments with fair value measurements using significant unobservable inputs (level 3) was as follows (in millions):

	Equity securities	Debt securities	Total
Beginning balance	$ —	$ 9	$ 9
Transfers into level 3	5	—	5
Total net gains (losses):			
Realized	—	—	—
Unrealized	—	—	—
Purchases	—	—	—
Sales	—	—	—
Settlements	—	—	—
Ending balance	$ 5	$ 9	$ 14
Total realized and unrealized year-to-date net gains (losses) related to assets held at March 31, 2017	$ —	$ —	$ —

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
Beginning balance	$ 12
Transfers out of level 3	—
Total net gains:	
Realized	1
Unrealized	—
Purchases	1
Sales	(1)
Settlements	(4)
Ending balance	$ 9
Total realized and unrealized year-to-date net gains (losses) related to assets held at December 31, 2016	$ —

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 three months ended March 31, 2017 and the year ended December 31, 2016, 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 March 31, 2017 and December 31, 2016, the values of these funds were $41 million and $44 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 March 31 2017, Hospitals had original commitments related to alternative investments of $8.0 billion, of which $4.9 billion was invested, leaving $3.1 billion of remaining commitments. 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.

For the three months ended March 31, investment income - net was comprised of the following (in millions):

	2017	2016
Other-than-temporary impairment	$ (50)	$ (170)
Recognized gains	356	219
Recognized losses	(58)	(84)
Income (loss) from equity method alternative investments	175	(96)
Interest, dividends, and other income - net	190	207
Derivative income (loss)	86	(128)
Total investment income (loss) - net	699	(52)
Less investment income included in operating income	(117)	(105)
Investment income (loss) - net	$ 582	$ (157)

For the three months ended March 31, 2017 and 2016, 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 both the three months ended March 31, 2017 and 2016, there was $1 million 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. At March 31, 2017, absolute return and risk parity investments of $685 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. At March 31, 2017, equity investment funds of $307 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 March 31, 2017 and December 31, 2016, 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 March 31, 2017 and December 31, 2016, the fair values of these agreements were $(239) million and $(251) million, respectively, and were recorded in other long-term liabilities. For both the three months ended March 31, 2017 and 2016, Health Plans and Hospitals recorded $8 million in interest expense relating to the Interest Rate Swaps. For the three months ended March 31, 2017 and 2016, net changes in fair values totaled $12 million and $(55) 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 March 31, 2017 and December 31, 2016, no collateral was required to be posted by either Health Plans and Hospitals or the counterparties.

(b) Derivatives Held in Investment Portfolios

At March 31, 2017 and December 31, 2016, Health Plans' and Hospitals' portfolio managers held $72 million and $46 million, respectively, of futures, forwards, options, and swaps to attempt to protect investments against volatility. For the three months ended March 31, 2017 and 2016, net changes in fair values totaled $24 million and $(28) million, respectively, and were recorded in investment income - net. For the three months ended March 31, 2017 and 2016, gains (losses) resulting from derivative settlements totaled $50 million and $(45) 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 three months ended March 31, 2017	2016
Interest rate swaps - related to debt	Investment income - net	$ 12	$ (55)
Interest rate swaps - other	Investment income - net	38	(18)
Options, rights, and warrants	Investment income - net	1	(1)
Futures and forwards	Investment income - net	(15)	(9)
		$ 36	$ (83)

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 three months ended March 31, 2017	2016
Interest rate swaps - related to debt	Interest expense	$ (8)	$ (8)
Interest rate swaps - other	Investment income - net	18	(40)
Futures and forwards	Investment income - net	27	(12)
Options, rights, and warrants	Investment income - net	5	7
		$ 42	$ (53)

Information on Fair Value of Derivative Instruments - Assets

(In millions)

Derivatives not designated as hedging instruments	Balance sheet category	Fair value at March 31, 2017	Fair value at December 31, 2016
Interest rate swaps - other	Noncurrent investments	$ 81	$ 47
Futures and forwards	Noncurrent investments	47	64
Options, rights, and warrants	Noncurrent investments	9	7
		$ 137	$ 118

Information on Fair Value of Derivative Instruments - Liabilities

(In millions)

Derivatives not designated as hedging instruments	Balance sheet category	Fair value at March 31, 2017	Fair value at December 31, 2016
Interest rate swaps - related to debt	Other long-term liabilities	$ 239	$ 251
Interest rate swaps - other	Other long-term liabilities	20	25
Futures and forwards	Other long-term liabilities	37	38
Options, rights, and warrants	Other long-term liabilities	8	9
		$ 304	$ 323

(7) Accounts Receivable - net

Accounts receivable - net were as follows (in millions):

	At March 31, 2017	At December 31, 2016
Members' dues	$ 936	$ 799
Patient services	527	387
Medicare	499	315
Reinsurance recoveries	137	150
Risk Adjustment receivables	15	15
Other	459	564
	2,573	2,230
Allowances for bad debt	(236)	(200)
Total	$ 2,337	$ 2,030

(8) Inventories and Other Current Assets

Inventories and other current assets were as follows (in millions):

	At March 31, 2017	At December 31, 2016
Inventories - net	$ 902	$ 832
Prepaid expenses	601	455
Other	102	70
Total	$ 1,605	$ 1,357

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

Land, buildings, equipment, and software - net were as follows (in millions):

	At March 31, 2017	At December 31, 2016
Land	$ 2,031	$ 1,884
Buildings and improvements	33,308	32,627
Furniture, equipment, and software	11,944	11,654
Construction and software development in progress	1,512	1,379
	48,795	47,544
Accumulated depreciation and amortization	(23,777)	(23,202)
Total	$ 25,018	$ 24,342

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 three months ended March 31, 2017 and 2016, Health Plans and Hospitals capitalized $4 million and $8 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 March 31, 2017 and December 31, 2016, the liability for asset retirement obligations was $106 million and $103 million, respectively. At March 31, 2017 and December 31, 2016, the unamortized asset related to these retirement obligations was $21 million and $19 million, respectively.

(10) Other Acquired Intangible Assets

At March 31, 2017, other acquired intangible assets were as follows (in millions):

	Weighted average amortization period	Gross carrying amount	Accumulated amortization	Net carrying amount
Intangible assets				
Amortizing intangible assets:				
Member relationships	9 years	133	(5)	128
Intellectual property	15 years	78	(1)	77
Other	10 years	112	(1)	111
Total intangible assets	11 years	$ 323	$ (7)	$ 316

Intangible assets subject to amortization are amortized on a straight-line or accelerated basis over their useful lives. For the period ended March 31, 2017, aggregate amortization expense related to amortizing intangible assets was $7 million.

The estimated aggregate amortization expense for the next five years at December 31 is as follows (in millions):

2017	$ 40
2018	44
2019	38
2020	33
2021	27

(11) Medical Claims Payable

Activity in the liability for medical claims payable was as follows (in millions):

	At March 31, 2017	At December 31, 2016
Balances at January 1	$ 1,862	$ 1,750
Acquired business at 2/1/2017	277	—
Incurred related to:		
Current year	2,822	9,117
Prior years	(5)	(144)
Total incurred	2,817	8,973
Paid related to:		
Current year	1,428	7,415
Prior years	1,246	1,446
Total paid	2,674	8,861
Ending balances	$ 2,282	$ 1,862

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.

(12) Other Liabilities

Other current liabilities were as follows (in millions):

	At March 31, 2017	At December 31, 2016
Self-insured risks	$ 403	$ 388
Dues collected in advance	994	682
Medicare liabilities	31	33
Physicians' retirement plan liability	185	185
TBA commitments	52	136
Other	756	678
Total	$ 2,421	$ 2,102

Other long-term liabilities were as follows (in millions):

	At March 31, 2017	At December 31, 2016
Self-insured risks	$ 1,627	$ 1,518
Derivatives liability	304	323
Due to associated medical groups	202	202
Other	368	337
Total	$ 2,501	$ 2,380

(13) Debt

Debt was as follows (in millions):

	At March 31, 2017	At December 31, 2016
Tax-exempt revenue bonds and taxable bonds and notes:		
0.68% to 2.00% variable rate due through 2052	$ 4,959	$ 5,107
3.60% to 4.92% fixed rate due through 2042	2,328	2,329
Others at various rates due through 2027	11	7
Total	$ 7,298	$ 7,443
Other current debt:		
Commercial paper	$ 1,738	$ 1,886
Current portion of long-term debt	18	18
Long-term debt subject to short-term remarketing arrangements - net	785	785
Long-term debt classified as a long-term liability	4,757	4,754
Total	$ 7,298	$ 7,443

At both March 31, 2017 and December 31, 2016, repurchase of variable rate bonds totaling $3.2 billion 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 both March 31, 2017 and December 31, 2016, 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 both March 31, 2017 and December 31, 2016, $785 million of these variable rate demand bonds were classified in current liabilities, net of available long-term credit facilities of $2.4 billion.

At March 31, 2017 and December 31, 2016, $29 million and $31 million, respectively, of the above tax-exempt fixed-rate revenue bonds represented a net unamortized premium balance. At March 31, 2017

and December 31, 2016, $(22) million and $(23) 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	$	1,756
2018		18
2019		247
2020		19
2021		19
Thereafter		5,232
Total	$	7,291

At March 31, 2017, 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 March 31, 2017, the facility fee was at an annual rate of 0.06%. At March 31, 2017 and December 31, 2016, 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 March 31, 2017 and December 31, 2016, commercial paper of $1.7 billion and $1.9 billion, respectively, was outstanding under this program and is included within other current debt.

(14) Pension Plans

(a) Defined Benefit Plan

Health Plans and Hospitals have defined benefit pension plans (Plans) 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 March 31, 2017 and December 31, 2016, substantially all pension fund assets were held in a group trust. At March 31, 2017 and December 31, 2016, trust assets were invested primarily in fixed-income and equity securities, with approximately 20% and 21%, respectively, of trust assets, net of liabilities, invested in alternative investments.

At December 31, 2016 the funded status of pension benefits was as follows (in millions):

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

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

The accrued pension plan liability at December 31, 2016 and the change through March 31, 2017 are as follows (in millions):

Accrued pension plan liability at December 31, 2016	$	6,807
Pension liability acquired through acquisition		74
Provision		246
Payments		(1,198)
Plan amendments		—
Accrued pension plan liability at March 31, 2017		5,929
Less: current portion		
Long-term portion of accrued pension liability at March 31, 2017	$	5,929

For the three months ended March 31, pension expense was as follows (in millions):

	2017	2016
Service cost	$ 311	$ 276
Interest cost	179	190
Expected return on plan assets	(244)	(200)
Amortization of net actuarial loss	68	51
Amortization of prior service cost	3	3
Net pension expense	317	320
Other changes in plan assets and PBO recognized in net worth:		
Amortization of net actuarial loss	(68)	(51)
Amortization of prior service cost	(3)	(3)
Total recognized in net worth	(71)	(54)
Total recognized in net periodic benefit cost and net worth	$ 246	$ 266

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:

	2017	2016
Discount rates at January 1 for calculating pension expense	4.15% - 4.45%	4.70%
Discount rate for calculating December 31 PBO	N/A	4.45%
Discount rates for calculating February 1 PBO	4.15% - 4.35%	N/A
Salary scale for calculating pension expense	3.00% - 4.50%	4.20%
Salary scale for calculating December 31 PBO	N/A	4.20%
Salary scale for calculating February 1 PBO	3.00% - 4.50%	N/A
Expected long-term rates of return on plan assets for calculating pension expense	5.25% - 7.00%	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 Plans whereby the Plans invest 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 Plans' 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 Plans. 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 March 31, 2017, 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	Total
Assets:			
Cash and cash equivalents	$ 392	$ 1,295	$ 1,687
Broker receivables	—	297	297
Securities lending collateral	—	790	790
U.S. equity securities	5,896	523	6,419
Foreign equity securities	5,210	2,117	7,327
Global equity funds	—	258	258
Debt securities issued by the U.S. government	—	1,090	1,090
Debt securities issued by U.S. government agencies and corporations	—	55	55
Debt securities issued by U.S. states and political subdivisions of states	—	204	204
Foreign government debt securities	—	504	504
U.S. corporate debt securities	—	4,331	4,331
Non-U.S. corporate debt securities	—	1,150	1,150
U.S. agency mortgage-backed securities	—	121	121
Non-U.S. agency mortgage-backed securities	—	54	54
Other	1	725	726
Total fair value of pension assets	11,499	13,514	25,013
Liabilities:			
Broker payables	—	663	663
Securities lending payable	—	790	790
Other liabilities	27	297	324
Total liabilities	27	1,750	1,777
Fair value of pension trust assets - net	$ 11,472	$ 11,764	23,236
Investments measured at NAV:			
Alternative investments:			
Absolute return			1,734
Private equity			3,509
Risk parity			611
Total pension trust assets - net			$ 29,090

At March 31, 2017, Health Plans' and Hospitals' share of pension trust assets was 47.4%, or $13.8 billion. The remaining share of pension trust assets is for Medical Groups and a related party associated with Medical Groups.

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	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
Total fair value of pension assets	10,008	12,926	22,934
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	$ 10,808	20,797
Investments measured at NAV:			
Alternative investments:			
Absolute return			1,670
Private equity			3,241
Risk parity			752
Total pension trust assets - net			$ 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.

During the three months ended March 31, 2017 and 2016, 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:

	2017 and 2016 target range	2016 ELTRA	2017 ELTRA
Cash and cash equivalents	0%-3%	3.00%	3.00%
Equity securities	43%-55%	8.65%	8.65%
Debt securities	28%-45%	5.50%	5.00%
Alternative investments	10%-25%	7.60%	7.25%
Total	100%	7.25%	7.00%

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 March 31, 2017, the trust had original commitments related to alternative investments of $7.0 billion, of which $3.7 billion was invested, leaving $3.3 billion of remaining commitments. 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.

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 March 31, 2017, absolute return and risk parity investments of $622 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. At March 31, 2017, debt and equity investment funds of $1.6 billion are redeemable between 10 and 30 days. Equity investment funds of $182 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 the three months ended March 31, 2017 and 2016, there were no required

employee contributions. For the three months ended March 31, 2017 and 2016, plan expense, primarily employer contributions, was $77 million and $57 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 three months ended March 31, 2017 and 2016 are 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 2017 and 2016 is for the plan's year-end in 2016 and 2015, 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 2017 and 2016 employer expense.

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Notes to Combined Financial Statements

For the three months ended March 31, 2017 and 2016

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 March 31, 2017	(in millions) Health Plans' and Hospitals' Contributions March 31, 2016	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	$ 3	$ 2	No	Yes	Yes	9/17/2018
Southern California United Food and Commercial Workers Unions and Drug Employers Pension Fund	516029925-001	Red	Red	Implemented	1	1	No	Yes	Yes	2/1/2020
Oregon Retail Employees Pension Trust[2]	936074377-001	Red	Red	Implemented	1	1	No	Yes	Yes	9/30/2018-10/31/2020
Other[3]	Various	Red	Red	Implemented	2	2	See Note 3	No	No	4/30/2018-10/31/2020
Other	Various	Green	Green		4	4		No	No	9/30/2017-12/31/2020
Other	Various	Yellow	Yellow		1	1		No	No	6/30/2017-6/30/2019
Total Expense					$ 12	$ 11				

(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.
(3) Surcharge imposed on the Sound Retirement Trust comprised of UFCQ Local 21 Pro-Tech & Optical and Pharmacy. The other red plan included in this grouping does not have a surcharge imposed.

(15) 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, vision benefits, and contributions to health care savings accounts.

At December 31, 2016, the accrued liability for postretirement benefits was as follows (in millions):

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

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

The accrued liability for postretirement benefits at December 31, 2016 and the change through March 31, 2017 are as follows (in millions):

Accrued postretirement benefits liability at December 31, 2016	$ 2,341
Postretirement benefits liability acquired through acquisition	39
Provision	52
Plan amendments	(41)
Plan contribution	—
Benefits paid or provided	(39)
Accrued postretirement benefits liability at March 31, 2017	2,352
Less: current portion	(3)
Long-term portion of accrued postretirement benefits liability at March 31, 2017	$ 2,349

For the three months ended March 31, postretirement benefits expense was as follows (in millions):

	2017	2016
Service cost	$ 42	$ 39
Interest cost	57	64
Expected return on plan assets	(47)	(25)
Amortization of net actuarial loss	26	34
Amortization of prior service credit	(108)	(108)
Postretirement benefits expense	(30)	4
Other changes in plan assets and benefit obligations recognized in net worth:		
Prior service credit	(41)	—
Amortization of net actuarial loss	(26)	(34)
Amortization of prior service credit	108	108
Total recognized in net worth	41	74
Total recognized in net periodic benefit cost and net worth	$ 11	$ 78

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 the three months ended March 31, 2017 and 2016, the employer contributions and benefits paid or provided were $39 million and $35 million, respectively. During 2017 and 2016, there were no participant contributions from active employees.

Actuarial assumptions used were as follows:

	2017	2016
Discount rates used for calculating postretirement benefits expense from January 1 to March 31	3.70% - 4.45%	4.75%
Discount rate for calculating December 31 accumulated postretirement benefit obligation	N/A	4.45%
Discount rate for calculating February 1 accumulated postretirement benefit obligation	3.70%	N/A
Expected long-term rate of return on plan assets for calculating benefits expense	6.00%	7.00%

The following were the assumed health care cost trend rates used to determine the December 31, 2016 benefit obligation and postretirement benefits expense for the three months ended March, 2017 and 2016:

	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 - 2016	5.50% / 5.25%	7.00% / 7.00%	4.00%	4.50%	5.25%	3.25%	5.50% / 5.25%
Initial trend rate - 2017	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	2016	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 March 31, 2017, 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	Total
Assets:			
Cash and cash equivalents	$ —	$ 424	$ 424
Other	—	2	2
Total fair value of retirement benefit trust assets	$ —	$ 426	426
Investments measured at NAV:			
Alternative investments:			
Absolute return			1,188
Risk parity			1,558
Total retirement benefit trust assets			$ 3,172

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	Total
Assets:			
Cash and cash equivalents	$ —	$ 201	$ 201
Other	—	2	2
Total fair value of retirement benefit trust assets	$ —	$ 203	203
Investments measured at NAV:			
Alternative investments:			
Absolute return			1,155
Risk parity			1,737
Total retirement benefit trust assets			$ 3,095

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

	2017 target range	2017 ELTRA
Alternative investments	100%	6.00%
Total	100%	6.00%

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 March 31, 2017, absolute return and risk parity investments of $213 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 both the three months ended March 31, 2017 and 2016, Health Plans' and Hospitals' employer expense for both current and retiree benefits was $21 million.

(16) 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, 2016 the accrued liability for physicians' retirement plan was as follows (in millions):

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

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

The accrued liability for the physicians' retirement plan liability at December 31, 2016 and the change through March 31, 2017 are as follows (in millions):

Accrued physicians' retirement plan liability at December 31, 2016	$	6,751
Provision		153
Payments		(44)
Accrued physicians' retirement plan liability at March 31, 2017		6,860
Less: current portion		(185)
Long-term portion of accrued physicians' retirement plan liability at March 31, 2017	$	6,675

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 three months ended March 31, physicians' retirement plan provision was as follows (in millions):

	2017	2016
Service cost	$ 87	$ 76
Interest cost	66	70
Amortization of net actuarial loss	17	12
Total benefit expense	170	158
Expected return on assets - investment income included in operating expenses	(117)	(105)
Net benefit expense	53	53
Other changes in projected benefit obligations recognized in net worth		
Amortization of net actuarial loss	(17)	(12)
Total recognized in net worth	(17)	(12)
Total recognized in net periodic benefit cost and net worth	$ 36	$ 41

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:

	2017	2016
Discount rate at January 1 for calculating benefit expense	4.55%	4.80%
Discount rate for calculating December 31 PBO	N/A	4.55%
Salary scale for calculating pension expense	4.40%	4.40%
Salary scale for calculating December 31 PBO	N/A	4.40%
Expected long-term rate of return on designated investments for calculating benefit expense	7.00%	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

(17) 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 three months ended March 31, 2017 and 2016, total lease expense for all leases was $123 million and $115 million, respectively.

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

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

During the three months ended March 31, 2017 and 2016, Health Plans' and Hospitals' total purchases under contracts with minimum purchase commitments were $101 million and $85 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 March 31, 2017 and December 31, 2016, Health Plans and Hospitals had entered into surety instruments and standby letters of credit that totaled $93 million and $87 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 March 31, 2017 and December 31, 2016, pursuant to such guarantees, Health Plan, Inc. and Hospitals are contingently liable for approximately $185 million and $180 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 March 31, 2017 and December 31, 2016, the regulatory net worth, so defined, exceeded the aggregate regulatory minimum requirements by approximately $27 billion and $25 billion, respectively.

Health Plans' regulated subsidiaries maintain investments in various states where they are licensed. At March 31, 2017 and December 31, 2016, $7 million and $6 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.

(18) Subsequent Events

On May 3, 2017, Hospitals received proceeds in connection with the issuance of $2.1 billion par value taxable fixed rate debt and $2.1 billion par value tax-exempt fixed rate debt. Total proceeds from issuance, which includes $200 million of bond premium, were $4.4 billion. The proceeds will be used for capital projects, general corporate purposes, and to redeem $1.4 billion of existing debt.