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STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

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OFFICE OF
INSURANCE COMMISSIONER

March 24, 2016

FRANK C MILLER
SENIOR COUNSEL
KAISER PERMAMENTE
ONE KAISER PLAZA, 19TH FLOOR
OAKLAND, CA 94612

ROBIN L. LARMER
COUNSEL
STOEL RIVES LLP
600 UNIVERSITY ST., #3600
SEATTLE, WA 98101

Re: Form A Filing – Statement Regarding the Acquisition of Control of Group Health Cooperative and Group Health Options by Kaiser Foundation Health Plan of Washington

Dear Mr. Miller and Ms. Larmer:

Receipt of the above Form A filing dated February 26, 2016, with the OIC on March 1, 2016. We are reviewing the information provided in the Form A filing and have some comments and request for information to supplement this filing.

General Items

The Form A issues:

1. Please identify the Ultimate Controlling Person(s), as defined under the Holding Company Act.
2. Please provide the specific contact information for the Applicant, KFHP of WA. (The Form A 'blends' KFHPWA into the general trade name 'Kaiser Permanente'.)
3. Please clarify that Kaiser Foundation Health Plans, Inc., Kaiser Foundation Hospitals, and all affiliates understand and intend to comply with all aspects of the WA Holding Company Act (Chapter 48.31B RCW) following any consummation of this Transaction.
4. Several of the Form A Exhibits had no 'as of' dates, so as to show currency.

Org Chart and Entity Comments:

1. Under Exhibit E - Kaiser Affiliated Entities, please provide the purpose and current operations for each entity listed; and in particular clarify the interaction between these affiliates.

2. It is noted that several of these entities are IRC 501(c)(3) charities, and file IRS Form 990. Please clarify whether or not there will be any (additional) charitable solicitation activities in Washington following the Transaction.

3. Within Exhibit I (Kaiser Annual Report 2014) refers to the following possible entities, not shown in the Org Chart or disclosed within Exhibit E: Please explain and amend the exhibits to show all affiliates.
   - The Permanente Federation, LLC
   - Kaiser Permanente PR and Communications
   - Kaiser Permanente Northern California Multimedia Communications

Directors and Officers of KFHP

We are missing an attachment to Ms. Heisz' response on her biographical affidavit.

Per Exhibit N, Hong-Sze Yu is "Assistant Secretary" for KFHP, but not listed as an Officer. If so, she should furnish a bio and verification. If a non-officer, does she have the authority to sign the Certificate on behalf of KFHP and KFH?

Are there any other non-disclosed Officers that should be disclosed?

Kaiser Foundation Health Plan of WA

Specific to KFHPWA please furnish, for the last two calendar years:

- Copies of the last two years of KFHPWA Board Minutes.
- Financial statements (balance sheet and income statements)
- Discussion of KFHPWA's solvency following transaction, specifically discussion loan obligations, repayment, and any impact to GHC. How would KFHPWA be expected to pay off the Note?
- The Form A (Exec Summary #4) states that KFHPWA will spend $1.0B in GHC and subs for capital improvements, and key investments in infrastructure over the next ten years. Please clarify where this money is projected to come from.

Group Health Community Foundation

1. A review of the Articles of Incorporation (Section 6.1) set the initial number of Foundation Directors at five. Bylaws Article V Section allows for 5-7 Directors during the first 18 months following incorporation, and then allows for expansion to 9-13 Directors. Please confirm the present number of Directors, and furnish a copy of the current D&O listing.
2. We note that that the initial Directors have all served as principals of GHC, and would ostensibly be protective of the continuing interests of GHC's current enrollees. Please clarify whether or not there has been any discussion or agreement to change this composition, following expansion, to favor the interests of Kaiser.
3. The Form A provides that KFHPWA will pay transaction consideration of $1.8B to GHCF. Please clarify whether these assets, once transferred to GHCF, will be unencumbered.
4. The Post-Transaction Org Chart does not make reference to Group Health Community Foundation. What is the reason?
5. Will the GHCF have separate audited financial statements or will be combined with another entity? If so, which entity?

We will have other questions regarding the Form A filing as they develop. Our review will continue as we wait for your response to this request.

If you have any questions, please feel free to contact me at (360) 725-7211.

Yours truly,

Ronald J. Pastuch

RONALD J. PASTUCH, CPA
Holding Company Manager
Company Supervision Division
E-Mail: RonP@oic.wa.gov

Cc: Mary Shea, CPA, Financial Analyst
Kris Graap, Holding Company Specialist
Darryl Colman, OIC Legal

Shawna M. Sweeney, Group Health Cooperative

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April 15, 2016

Mr. Ronald J. Pastuch, CPA
Holding Company Manager, Company Supervision Division
Washington State Office of the Insurance Commissioner
PO Box 40249
Olympia, WA 98504-0259

Re: Proposed Acquisition of Group Health Cooperative by Kaiser Foundation Health Plan of Washington – Response to Form A First Supplemental Request

Dear Ron:

Thank you for your continued review of the Form A. In accordance with the Status Report dated March 31, 2016, following are Kaiser Foundation Health Plan of Washington's ("*KFHPW*"), responses to your First Supplemental Request dated March 24, 2016.

A. The Form A Issues:

1. Please identify the Ultimate Controlling Person(s) as defined under the Holding Company Act.

Response
The Ultimate Controlling Person is Kaiser Foundation Health Plan, Inc.

2. Please provide the specific contact information for the Applicant, KFHPW.

Response
The contact information for KFHPW is as follows:

Hong-Sze Yu, Assistant Secretary
Kaiser Foundation Health Plan of Washington
One Kaiser Plaza, 19th Floor
Oakland, CA 94612

3. Please clarify that Kaiser Foundation Health Plans, Inc., Kaiser Foundation Hospitals, and all affiliates understand and intend to comply with all aspects of the WA Holding Company Act (Chapter 48.31B RCW) following any consummation of this transaction.

Response
Kaiser Foundation Health Plan, Inc. and all affiliates within the holding company system, understand their obligations under the WA Holding Company Act, and intend to comply with all provisions of the Act as are applicable to each affiliate following consummation of this transaction.

4. Several of the Form A Exhibits had no 'as of' dates, so as to show currency.

Response
All Form A Exhibits, except Exhibit K, have been revised to show 'as of' dates and have been resubmitted. Exhibits E and J have also been revised to reflect the changes addressed below, and a new Exhibit Q has been added (see Section D (1)(a), below). A revised Table of Exhibits accompanies this transmission

As with the initial Form A submission, all *Confidential Exhibits* (as defined in the initial Form A submission) will be delivered to your office in hard copy only, via U.S. Mail.

With respect to Exhibit K, as discussed in Section C, below, a replacement biographical affidavit (for Ms. Heisz) and two additional biographical affidavits (for Mr. Yu and Dr. Washington) have been delivered to you in hard copy only, via U.S. Mail. An additional biographical affidavit for Ms. Mullaney will be provided in a supplemental submission.

B. Org Chart and Entity Comments:

1. Under Exhibit E – Kaiser Affiliated Entities, please provide the purpose and current operations for each entity listed; and in particular clarify the interaction between these affiliates.

Response
Exhibit E has been revised to include additional detail and is included in this transmission.

2. It is noted that several of these entities are IRC 501(c)(3) charities, and file IRS Form 990. Please clarify whether or not there will be any (additional) charitable solicitation activities in Washington following the Transaction.

Response
There will be no additional charitable solicitation activities in Washington following the Transaction.

3. Within Exhibit I (Kaiser Annual Report 2014) refers to the following possible entities, not shown in the Org Chart or disclosed within Exhibit E: Please explain and amend the exhibits to show all affiliates.

Response
The following entities were not included within Exhibit E because they are not affiliates of KFHP. Specifically:

a. *The Permanente Federation, LLC*: This entity is controlled by the Permanente Medical Groups and is not an affiliate of KFHP, Inc.
b. *Kaiser Permanente PR and Communications*: This is a Kaiser department and not a separate legal entity or affiliate of KFHP, Inc.
c. *Kaiser Permanente Northern California Multimedia Communications*: This is a Kaiser department and not a separate legal entity or affiliate of KFHP, Inc.

C. Directors and Officers of KFHP:

1. We are missing an attachment to Ms. Heisz' response on her biographical affidavit.

Response
Ms. Heisz' replacement biographical affidavit, with all attachments, has been delivered to your office in hard copy only, via U.S. Mail.

2. Per Exhibit N, Hong-Sze Yu is "Assistant Secretary" for KFHP, but not listed as an Officer. If so, he should furnish a bio and verification. If a non-officer, does he have the authority to sign the Certificate on behalf of KFHP and KFH?

Response

Mr. Yu is an Executive Officer. His biographical affidavit has been delivered to your office in hard copy only, via U.S. Mail. His biographical affidavit has also been forwarded to the vendor for verification and completion of a background check, and the vendor will forward a report directly to your attention upon completion.

3. Are there other non-disclosed Officers that should be disclosed?

Response
In addition to Mr. Yu, there is one individual who has become a Director, and one individual who has become an Executive Officer, subsequent to the filing of the Form A. They are:

a. Dr. A. Eugene Washington, Director, KFHP, Inc. Dr. Washington's biographical affidavit will be delivered to you in hard copy only, via U.S. Mail. His biographical affidavit has also been forwarded to the vendor for verification and completion of a background check, and the vendor will forward a report directly to your attention upon completion.

b. Susan Mullaney, Regional President (Designate), KFHPW. Ms. Mullaney's biographical affidavit is in the process of completion and once complete, will be delivered to you in hard copy only, via U.S. Mail. Her biographical affidavit will also be forwarded to the vendor for verification and completion of a background check, and the vendor will forward a report directly to your attention upon completion.

Exhibit J, Kaiser List of Directors and Executive Officers, has been revised to include Mr. Yu, Dr. Washington and Ms. Mullaney.

D. Kaiser Foundation Health Plan of Washington:

1. Specific to KFHPWA please furnish, for the last two calendar years:

a. Copies of the last two years of KFHPWA Board Minutes.

Response
Copies of the Board Minutes (Exhibit Q) have been delivered to you in hard copy only, via U.S. Mail.

b. Financial statements (balance sheet and income statements).

Response
KFHPW is a holding company. It has no current operations, and had no financial activity prior to December 2015. KFHP, Inc. first set up KFHPW on its General Ledger in December 2015. The December 31, 2015 balance sheet contained investments offset by KFHPW's intercompany Note (Exhibit M).

c. Discussion of KFHPWA's solvency following transaction, specifically discussion of loan obligations, repayments and any impact to GHC. How would KFHPWA be expected to pay off the Note?

Response
The process and time frame for repayment of the Note has not been determined. It is anticipated that the source of repayment (if any) will be net income generated by GHC post-closing. KFHPW will update this response as additional decisions are made and more information is available.

d. The Form A (Exec Summary #4) states that KFHPWA will spend $1.0B in GHC and subs for capital improvements, and key investments in infrastructure over the next ten years. Please clarify where this money is projected to come from.

The transaction consideration payable to GHCF includes amounts reflecting cash currently on GHC's balance sheet. It is anticipated that the capital expenditures for GHC will be funded by the GHC balance sheet and cash flow. GHC currently has substantial cash and net worth, and little diminution over time is anticipated.

E. Group Health Community Foundation:

1. A review of the Articles of Incorporation (Section 6.1) set the initial number of Foundation Directors at five. Bylaw Article V Section 2 allows for 5-7 Directors during the first 18 months of incorporation, and then allows for expansion to 9-13 Directors. Please confirm the present number of Directors, and furnish a copy of the D&O listing.

Response
Group Health Community Foundation ("*GHCF*") currently has five (5) Directors.

Section 6.2 of the GHCF Articles of Incorporation identify the current Directors: Susan J. Byington, Robert A. Watt, Porsche Everson, Leo F. Greenawalt, Jr. and Ruta E. Fanning.

GHCF's Current Executive Officers are: Susan J. Byington (Chair), Robert A. Watt (Vice Chair), Diana Birkett Rakow (President), Ruta E. Fanning (Treasurer), and Sarah B. Yates (Secretary).

2. We note that the initial Directors have all served as principals of GHC, and would ostensibly be protective of the continuing interests of GHC's current enrollees. Please clarify whether or not there has been any discussion or agreement to change this composition, following expansion, to favor the interests of Kaiser.

Response
All current and future Directors of GHCF will continue to have a fiduciary obligation to act in furtherance of the purpose of GHCF as described in its Articles of Incorporation and Bylaws.

GHCF will be operated as a nonprofit organization completely independent from Kaiser Permanente, including an independent Board of Directors. There are no discussions or agreements to change the composition of the Board of Directors following the acquisition, if approved, to favor Kaiser's interest. If the acquisition is approved, the acquisition agreement provides that GHCF has the right to enforce Kaiser's commitments and obligations regarding community benefit and capital expenditures as set forth in the acquisition agreement.

3. The Form A provides that KFHPWA will pay transaction consideration of $1.8B to GHCF. Please clarify whether these assets, once transferred to GHCF, will be unencumbered.

Response
All transaction consideration received by GHCF will be unencumbered.

4. The Post-Transaction Org Chart does not make reference to Group Health Community Foundation. What is the reason?

Response
GHCF will be operated as a nonprofit organization that is completely separate and independent from Kaiser Permanente and Group Health.

5. Will the GHCF have separate audited financial statements or will be combined with another entity? If so, which entity?

Response
Yes, and if the acquisition is approved, GHCF will become the sole member of Group Health Foundation ("*GHF*"). It is anticipated that GHCF and GHF will produce consolidated audited financial statements.

I hope the above information is helpful. If you have additional questions or require additional information, please feel free to contact me at any time.

Best regards,

Robin L. Larmer

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ROBIN L. LARMER
Direct 206.386.7667
robin.larmer@stoel.com

July 22, 2016

Mr. Ronald J. Pastuch, CPA
Holding Company Manager, Company Supervision Division
Washington State Office of the Insurance Commissioner
PO Box 40249
Olympia, WA 98504-0259

Re: ***Proposed Acquisition of Group Health Cooperative by Kaiser Foundation Health Plan of Washington – Second Supplement and Amendment to Form A***

Dear Ron:

Thank you for your continued review of Kaiser Foundation Health Plan of Washington's ("*KFHPW*") Form A dated February 29, 2016 and Response to Form A First Supplemental Request ("*First Supplement*") dated April 15, 2016. KFHPW submits this Second Supplement and Amendment to Form A ("*Second Supplement*") to revise and/or update certain information in the Form A to reflect developments subsequent to its submission.

A. KFHPW Leadership

As indicated in the First Supplement, Susan Mullaney was designated to be the Regional President of KFHPW upon the departure of Donna Lynne, then the Executive Vice President for KFHPW with oversight responsibility for this Transaction. Ms. Lynne has left the organization, and the transition of her duties relative to this Transaction has been completed. Ms. Mullaney's current title is Regional President Designate, KFHPW.

In addition, Benjamin Chu, MD, formerly Kaiser Foundation Health Plan, Inc's ("*KFHP*") Executive Vice President with responsibility as Regional President for Southern California and Group President for Georgia, has left the organization. Gregory Adams, Executive Vice President and Group President for KFHP, has assumed Group President responsibility for all KFHP Regions.

Finally, two individuals were inadvertently omitted from the list of executive officers: Bernard J. Tyson, President and Chief Executive Officer for KFHP and KFHPW (identified as a Director in the initial submission) and Alfonse Upshaw, Senior Vice President, Corporate Controller and

Chief Accounting Officer for KFHP and KFHPW. The enclosed list of executive officers and directors (Exhibit J) has been revised to reflect these changes and additions.

Biographical affidavits for Susan Mullaney and Alfonse Upshaw will be delivered to you in hard copy under separate cover. They have also been forwarded to the third party vendor engaged by KFHPW for verification and background checks, and the reports will be sent to you directly by the vendor. Biographical Affidavits for Bernard Tyson and Gregory Adams were previously submitted.

B. Conditional Appointment of the Post-Transaction Group Health Cooperative Board of Directors

KFHPW has conditionally appointed the provisional members of the post-Transaction Board of Directors of Group Health Cooperative ("*GHC*"), with such appointments expressly contingent upon closing of the Transaction.[1] The Report Regarding Election of Directors of Group Health Cooperative, identifying and indicating the conditional appointment of the provisional directors of GHC (Exhibit R[2]), will be delivered to you in hard copy under separate cover. Because these appointments are conditional, and the current GHC Board of Trustees will continue to serve until immediately prior to closing of the Transaction, KFHPW requests that the names of the post-Transaction provisional directors not be disclosed at this time to avoid member confusion and concern regarding the leadership of GHC.

The biographical affidavits for the provisional directors for whom affidavits are not already on file with the OIC will be delivered to you in hard copy under separate cover. They have also been forwarded to the third party vendor engaged by KFHPW for verification and background checks, and the reports will be sent to you directly by the vendor.

Additionally, KFHPW reported in the Form A (Item 5, page 10) that the Chief Financial Officer ("*CFO*") of KFHP would be among the post-Transaction Directors for GHC. KFHPW no longer intends for the KFHP CFO to serve on the post-Transaction board, and instead will appoint the Regional President of KFHPW, and hereby updates the Form A accordingly.

[1] It is anticipated that the post-Transaction Board of Directors for Group Health Options will be identical.
[2] A revised Table of Exhibits accompanies this transmission.

C. Changes in Post-Transaction GHC Management Team

As reported on the Form A (Item 5), KFHPW anticipates relative stability and continuity in GHC staff following closing of the Transaction. However, it has recently been determined that some of the individuals currently holding management positions with GHC will not remain in those roles.

The GHC management positions for which a change in incumbent is anticipated, and the identity of the successors, to the extent known, are identified in Exhibit S, which will be delivered to you in hard copy under separate cover. Because these changes have not yet been announced to GHC staff, KFHPW requests that the changes not be publicly disclosed at this time to allow current leadership the opportunity to share the information with staff directly.

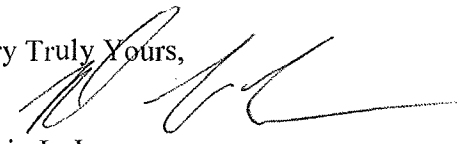
We understand that the current Executive Officers of GHC have biographical affidavits on file with the OIC. To the extent that any incoming Executive Officers for GHC do not have biographical affidavits on file with the OIC, we will ensure that they are promptly submitted.

D. Transition and Integration

As we have discussed, if the Transaction is approved, a significant amount of work will be required in order to ensure a successful transition and in particular, to prevent member disruption and confusion. KFHPW is currently engaged in transition planning, and we appreciate the opportunity to meet with you and other OIC staff in the coming weeks to discuss KFHPW's plans and intended approach to completion of the key transition activities. We look forward to working collaboratively with the OIC as transition and integration planning proceeds.

Again, thank you for your continued efforts in connection with the Form A. If you have additional questions or require additional information, please feel free to contact me at any time.

Very Truly Yours,



Robin L. Larmer

Cc: Frank C. Miller, Kaiser Foundation Health Plan, Inc.
Shawna M. Sweeney, Group Health Cooperative

TABLE OF EXHIBITS

Current as of July 22, 2016

Exhibit	Description	Confidential – Exempt from Public Disclosure	Redaction Required	Reference
A	Group Health Cooperative Organizational Chart	No	No	
B	Acquisition Agreement	No	No	
C	Group Health Cooperative Articles of Incorporation and By-Laws	No	No	
D	Kaiser Organizational Chart	No	No	
E	Kaiser Affiliated Entities	No	No	
F	Map of Kaiser Regions	No	No	
G	Kaiser Community Benefit Report	No	No	
H	Kaiser Audited Financial Statements	No	No	
I	Kaiser Annual Report	No	No	
J	Kaiser List of Directors and Executive Officers	No	No	
K	Kaiser Biographical Affidavits	Yes	Yes (if disclosed)	RCW 42.56.050, 42.56.070(1)
L	Escrow Agreement	No	No	

M	Kaiser Note for Intercompany Loan	Yes		RCW 48.31B.015(2)(B), 48.31.025(c)(i), 48.31B.038(1), 42.56.400(8), 48.02.65(6)
N	Secretary's Certificate – Kaiser	No	No	
O	Secretary's Certificate – GHC	No	No	
P	Three-Year Projections	Yes		RCW 19.108.010(4), 42.56.400(8), 48.02.65(6)
Q	KFHPW (formerly OHP) Board Minutes	Yes		RCW 19.108.010(4), 42.56.400(8), 48.02.65(6)
R	Report Regarding Election of Directors of Group Health Cooperative	No*	No	*Delayed disclosure requested (see Second Supplement to Form A)
S	Anticipated Group Health Cooperative Management Changes	No*	No	*Delayed disclosure requested (see Second Supplement to Form A)

ADDITIONAL MATERIALS SUPPORTING THE APPLICATION

GHCF Bylaws and Articles of Incorporation

KFHPW Certificate of Good Standing

List of Executive Officers and Directors (2nd Revised)
Current as of July 22, 2016

Directors of Kaiser Foundation Health Plan Inc. and Kaiser Foundation Health Plan of Washington

Ramón Baez
Regina M. Benjamin, MD, MBA
Jeffrey E. Epstein
Leslie S. Heisz
David F. Hoffmeister
Judith A. Johansen, JD
Kim J. Kaiser
Philip A. Marineau
Edward Pei
Margaret Porfido, JD
Richard P. Shannon, MD
Cynthia A. Telles, PhD
Bernard J. Tyson
A. Eugene Washington, MD

Executive Officers of Kaiser Foundation Health Plan, Inc

Bernard J. Tyson – Chairman of the Board, President and Chief Executive Officer
Gregory Adams - Executive Vice President & Group President
Patrick Courneya, MD - Executive Vice President and Chief Medical Officer
Dick Daniels - Executive Vice President & Chief Information Officer
Kathy Lancaster - Executive Vice President & Chief Financial Officer
Thomas R. Meier - Senior Vice President & Treasurer
Arthur M. Southam, MD - Executive Vice President, Health Plan Operations
Alfonse Upshaw – Senior Vice President, Corporate Controller and Chief Accounting Officer
Hong-Sze Yu, Assistant Secretary
Mark S. Zemelman - Senior Vice President, General Counsel and Secretary

Executive Officers of Kaiser Foundation Health Plan of Washington

Bernard J. Tyson – Chairman of the Board, President and Chief Executive Officer
Kathy Lancaster - Executive Vice President & Chief Financial Officer
Susan Mullaney – Regional President, Designate
Thomas R. Meier - Senior Vice President & Treasurer
Arthur M. Southam, MD - Executive Vice President, Health Plan Operations
Alfonse Upshaw – Senior Vice President, Corporate Controller and Chief Accounting Officer
Hong-Sze Yu, Assistant Secretary
Mark S. Zemelman - Senior Vice President, General Counsel and Secretary

REPORT REGARDING ELECTION OF DIRECTORS OF GROUP HEALTH COOPERATIVE

Management recommends that, contingent upon closing of the acquisition of Group Health Cooperative by Kaiser Foundation Health Plan of Washington, that Kaiser Foundation Health Plan of Washington, as the sole member of Group Health Cooperative upon closing, elect the persons listed below to be directors of Group Health Cooperative for a three year term, subject to adjustment of term and additional appointments in accordance with the corporate bylaws. The resumes of Ruta Fanning, Constance Rice and Michael Wilson are attached.

PROPOSED RESOLUTION

WHEREAS, Group Health Cooperative, Group Health Community Foundation, and Kaiser Foundation Health Plan of Washington have previously entered into that certain Acquisition Agreement (as the same may be amended, supplemented or otherwise modified from time to time, the "Acquisition Agreement"), dated as of December 2, 2015, pursuant to which Kaiser Foundation Health Plan of Washington will become the sole member of Group Health Cooperative (the "Acquisition"); and

WHEREAS, in anticipation of and continent upon closing of the Acquisition, Kaiser Foundation Health Plan of Washington adopts the following resolution in connection with and in furtherance of the foregoing.

NOW THEREFORE BE IT RESOLVED, subject to Section 5.3 of the Acquisition Agreement, the following persons be, and each of them hereby is designated, appointed and elected, effective as of immediately prior to the Closing Time (as defined in the Acquisition Agreement), as a Director of Group Health Cooperative, for a three year term, subject to adjustment of term and additional appointments in accordance with the Group Health Cooperative bylaws, or until his or her earlier resignation or removal:

- Gregory A. Adams
- Patrick T. Courneya, MD
- Ruta Fanning
- Judith A. Johansen
- Kim J. Kaiser
- Susan Mullaney
- Margaret E. Porfido
- Constance Rice, PhD
- Michael D. Wilson

Ruta Fanning

Resides in: Olympia

Education: Bachelor's degree in biology, Pacific Lutheran University; master's degree in public administration, University of Washington

Professional background: Career began in private sector finance and moved to Washington state service including 28 years of senior executive-level positions such as director of the Office of Financial Management. Former positions include director of the Higher Education Coordinating Board and vice president for Finance & Administration, The Evergreen State College. Most recently served as the legislative auditor, Joint Legislative Audit and Review Committee.

Ruta currently serves on the Group Health Cooperative Board of Trustees. Other Board experience includes Nisqually Land Trust, Citizen Commission for Tax Preferences, and The Olympian Editorial Board.

Constance W. Rice

Constance W. Rice was appointed by the Governor to the University of Washington's (UW) 10-member Board of Regents in 2013. As the state's flagship university, UW serves more than 92,000 students with 50 locations in 10 countries, houses one of the nation's premier medical schools, and is among the state's largest employers.

Dr. Rice is the Senior Executive Fellow for Casey Family Programs; the nation's largest operating foundation focused on safely reducing the need for foster care and building Communities of Hope for children and families across America. Founded in 1966, Casey Family Programs works in 50 states, the District of Columbia and Puerto Rico to influence

long-lasting improvements to the safety and success of children, families and the communities where they live.

Dr. Rice was formerly the Managing Director for Knowledge Management for Casey Family Programs. The team provides subject matter content for strategic consultants working in 50 states and jurisdictions. Information includes, but is not limited to, child protection policy, immigration, best practices, education, employment, housing, mental health, and kinship care.

A tireless activist and civic volunteer, Dr. Rice has made her mark in many areas of national and international service. As founder and past president of Strategic Education Centers, Dr. Rice and her advisory board established two educational centers in Swaziland.

Dr. Rice also served as the national founding Executive Director of the Desmond Tutu Peace Foundation, U.S.A. Dedicated to establishing the Desmond Tutu Peace Centre in Cape Town, South Africa, the foundation is now located in New York City.

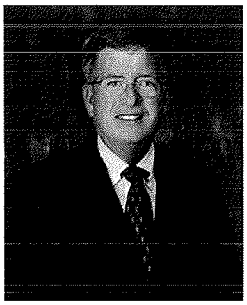
Dr. Rice is also known for her establishment of the Health and Nutrition Programs for seven elementary schools which provided evening dinners for the students and their families and educational workshops on budgeting, anger management, tutoring, and urban gardening. In addition, Dr. Rice has partnered with the Meredith Mathews YMCA to launch the 2011/2012 global scholar program in conjunction with the Black Achievers Project. Dr. Rice has also lectured extensively on the importance of Diversity in Tokyo, Osaka, Kyoto, and Kobe.

Dr. Rice is the former Vice Chancellor, and Senior Chancellor of Seattle Community Colleges. She also served as interim president of North Seattle Community College and is a former affiliate faculty member at the University of Washington's Department of Human Centered Design & Engineering. Dr. Rice was the chair of Women and Ethnic studies at Shoreline Community College. Dr. Rice holds a graduate degree from the University of Washington, Evans School of Public Policy & Governance, and a doctor of philosophy from the University of Washington, College of Education.

Dr. Rice has had leadership positions in the following boards: Seattle Community College District, Seattle Art Museum Executive Board Community and Education Engagement Committee, and served as a gubernatorial appointee to the Washington Student Achievement Council and was its Vice Chair. Dr. Rice served on the University of Washington Visiting Committee for the Evans School. She is the past national western area Vice Director of The Links, Incorporated, and served on the Board of Directors Downtown Rotary, the Rainier Club, The Seattle Foundation, and Swedish Hospital. Numerous civic and humanitarian organizations have honored Dr. Rice for her industrious, unflagging community service.

Dr. Rice is married to Norman B. Rice, former Mayor of the City of Seattle.

Michael D. Wilson



Mike Wilson is a health care consultant from Spokane. He was formerly the Chief Executive Officer at Providence Health Care, and after he retired he was called back to Providence to serve an additional two years.

His career spans 35 years in healthcare management including his most recent position. Wilson retired as President and Chief Executive Officer of Sacred Heart Medical Center, Children's Hospital and Holy Family Hospital but was called back to service in 2011. Mike has served as Chief Operating Officer, President and/or Chief Executive Officer throughout his 21-year career at Sacred Heart.

He received his Bachelors of Arts degree from Pacific Lutheran University in Tacoma, and received his MBA in business and public administration from Southeastern University in Washington, D.C. He has held leadership positions in many community organizations, healthcare organizations, and has served on a variety of boards and advisory committees during his career. Mike was appointed by the Governor of Washington in 2013 to the Board of Directors for the Health Sciences & Services Authority of Spokane County (HSSA).

Mike currently is working with an emerging entrepreneurial health care company.

Exhibit S

Anticipated Group Health Cooperative Management Changes
Current as of July 22, 2016

GHC Position	Current Incumbent	Change post-Transaction
President and Chief Executive Officer	Scott Armstrong	Susan Mullaney, currently Regional President Designate for Kaiser Foundation Health Plan of Washington, will become Regional President
Executive Vice President and Chief Financial Officer	Linda Breard	Karen Schartman, currently Vice President and Chief Financial Officer for Kaiser Foundation Health Plan of the Northwest, will become Chief Financial Officer
Executive Vice President and Chief Information Officer	Sue Kozik	Replacement to be determined
Executive Vice President, Health Plan Division (Health Plan Operations)	Robert O'Brien	Replacement to be determined

rrc risk&regulatory CONSULTING

August 18, 2016

Frank C Miller
Senior Counsel
Kaiser Permanente
One Kaiser Plaza, 19th Floor
Oakland, CA 94612

Robin L. Larmer
Counsel
Stoel Rives LLP
600 University St., #3600
Seattle, WA 98101

Re: Form A Filing – Statement Regarding the Acquisition of Control of Group Health Cooperative and Group Health Options by Kaiser Foundation Health Plan of Washington.

Dear Mr. Miller and Ms Larmer,

The State of Washington, Office of the Insurance Commissioner (OIC) received the above Form A filing dated February 26, 2016 on March 1, 2016. As a result of the filing the OIC sent you a correspondence on March 24, 2016 and Stoel Rives LLP provided a response to the inquiries on April 15, 2016 along with further information. The responses and documentation provided have been reviewed and have generated the following inquiries.

A. The Form A Inquiries:

1) As indicated in the April 15, 2016 response from Stoel Rives, Group Health Community Foundation (GHCF) will be operated as a nonprofit organization that is completely separate and independent from Kaiser Permanente and Group Health. Please provide an organizational chart depicting the organizational structure for GHCF post acquisition.
2) A $2B Note was entered in to between Kaiser Foundation Health Plan of Washington (KFHPW) and [redacted], whereby [redacted]s the lender. In accordance with the Acquisition Agreement, Article II, $1.8B will be transferred from KFHPW to Group Health Community Foundation (GHCF) at closing of the transaction, as the consideration for the transaction. GHCF resides outside the Group Health and Kaiser organizations. Please provide a justification for the consideration of the acquisition being paid to GHCF as opposed to the acquired entity, Group Health Cooperative (GHC).
3) In the April 15, 2016 response to D(1)(c) as related to the repayment of the $2B note, it stated that the time frame for the repayment on the note is unknown and the repayment is anticipated to be generated by GHC post acquisition net income. The repayment is on demand and accrues interest as follows: yearly rate equal to the rate at which the proceeds hereof actually accrue interest (to the extent held in a deposit account) and realize investment income (to the extent held in a securities account). Since $1.8B of the proceeds from the Note will be sent to GHCF, how is this calculated?
4) The purpose of the $2B Note is that KFHPW represents and warrants to [redacted]that the loan evidenced by this Note is

not for personal, family, household or consumer purposes. Please provide a more specific purpose for the loan.

5) As referenced in the "Acquisition Agreement", Section 3.2(c), Evercore Group LLC was engaged to provide an opinion to the effect that the purchase price, as reduced by the aggregate member capital dues, to be paid by KHFPW to GHCF is fair to GHC from financial stand point. Evercore Group LLC is GHC's financial advisor. Please provide a copy of this opinion.
6) Provide an audited financial statement for KFHPW as of 12/31/2015.
7) In the response to the Form A questions received on 4/15/2016, a biographical affidavit was received for Leslie Stone Heisz. [redacted]
8) [redacted]
9) KFHP is the sole member of KFHPW, KFPH has control over members, changes in rights to the members, election and removal of Directors and filling any of the vacancies on the Board. In turn, post acquisition KFHPW is the sole member of GCH. KFHP and KFHPW have the same Directors and KFHPW the same executive officers as KFHP. If these are accurate statements, why wasn't the acquisition structure for GCH to be a direct affiliate of KFHP post acquisition?
10) The Form B, Holding Company Registration Statement supplied was for Kaiser Foundation Health Plan of Northwest which does not appear to have any bearing on the acquisition of Group Health Cooperative. How is this Form B filing relevant to the Kaiser Foundation Health Plan of Washington acquisition?
11) Do the Corporate Bylaws of GHC require the creation of a Consumer Advisory Committee of at least 25 people to provide GHC's member with an opportunity to participate in matters of policy and operations? Please provide a proposed post acquisition copy of the GHC By-Laws.
12) The Escrow Agreement is between GHC and GHCF and KFHPW whereby KFHPW places $75M in the escrow account. At the end of the escrow the outstanding amounts in the escrow will be distributed to GHCF. Why do these escrow distributions go to GHCF which is outside the Group Health Cooperative organizational structure?
13) The GHC members can elect to receive a refund of $175 of the $200 membership fee or donate it to GHF, which after the acquisition GHF will not be part of the Group Health Organization. In essence as part of the acquisition, the members will be losing their membership, so why are they being charged a per member refund fee of $25?
14) In general, the Kaiser organization provides services through several intercompany service agreements such as claims, billing and other administrative functions. Identify each service that GHC becomes a party to if the acquisition is effectuated and provide a copy of each intercompany agreement. Additionally, provide a summary of the fees associated with each service as related to the intercompany agreements.
15) Please provide a list and copy of any agreements that are going to be in entered in to as a result of the Acquisition Form A filing. It is not necessary to provide any agreements already provided for #14 above.
16) The following are questions relate to the 12/31/2016 through 12/31/2019 statutory proformas:
    a. When Group Health Foundation is removed as an affiliate from GHC per Article II of the Acquisition Agreement, how much does that reduce the assets and surplus of GHC? Is this reflected in the proformas?
    b. On the proformas balance sheet there is a line for "Aggregate write-ins for Other Liabilities" projected to be in excess of $300M for all proforma years. Please itemize the liabilities and provide an explanation.
    c. In 12/31/2016 there is a liability for "Borrowed Money and Interest" in the amount of $90M. What does this liability represent?
    d. In years 2017 through 2019 please provide a breakdown for the Medical Services expenses ranging from $3.0BM to $3.6B.

e. In years 2017 through 2019 please provide a breakdown for the Administrative and Other expenses ranging from $378M to $448M.
f. In years 2017 through 2019 please provide a breakdown for the Capacity and Capabilities expenses ranging from $41M to $57M.
g. In years 2017 through 2019 please provide a breakdown for the Additional Community Benefit expenses ranging from $9M to $36M. Is this part of the $800M charitable contributions over the next 10 years? How much of the $800M will be funded by GHC?
h. In years 2017 to 2019 there is increasing additional depreciation, is this related to the $1B commitment for capital improvements? How much of the $1B in capital improvements is attributable to GHC?

17) For employees with non collective bargaining agreements, KFHPW has committed to provide current employees with compensation and benefits equal or greater to the compensation and benefits provided as of the closing of the transaction for a minimum of nine months. Will any long-term benefits such as pensions remain in effect subsequent to the nine month period?
18) Will the enrollees retain their current rate post acquisition? And if they do, for what period do they retain their current rate? Has an actuarial analysis been performed on the rates and if so, what would be the projected rate increase/decrease results for the next year, 3 three years and five years? Please provide a copy of the actuarial analysis indicating support for the acquisition.
19) Donna Lynne executed the Form A Filing for KHFPW as of February 26, 2016, however as of July 22, 2016 she is no longer an Executive Officer of Kaiser Foundation of Health Plan of Washington. Verify that her separation is not a result of inaccuracies in the statements submitted in the Form A filing and confirm that the information in the Form A filing is accurate.

In an effort to move the Form A review forward, please return the requested response and supporting documentation as soon as practicable. My contact information is listed below; please feel free to contact me if you have any questions.

Best Regards,

Karen Heburn

Karen Heburn
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November 10, 2016

Mr. Ronald J. Pastuch, CPA
Holding Company Manager, Company Supervision Division
Washington State Office of the Insurance Commissioner
PO Box 40249
Olympia, WA 98504-0259

Re: ***Proposed Acquisition of Group Health Cooperative by Kaiser Foundation Health Plan of Washington – Third Supplement and Amendment to Form A***

Dear Ron:

Thank you for your continued review of Kaiser Foundation Health Plan of Washington's ("*KFHPW*") Form A dated February 29, 2016, and KFHPW's subsequent First and Second Supplements to Form A and Response to RRC's Requests (collectively, the "*Form A*"). KFHPW submits this Third Supplement to update certain information in the Form A and to respond to questions raised by RRC in its Report dated October 26, 2016. This Supplement and the attachments thereto constitute Confidential Information, and are submitted in hard copy only.

Post-Transaction Executive Leaders

In Exhibit S to the Form A, submitted on July 22, 2016, KFHPW identified anticipated changes in the post-Transaction management team for Group Health Cooperative, including changes in the roles of Chief Information Officer and Executive Vice President for Health Plan Operations. At the time of submission, KFHPW had not yet identified the individuals who would fill those roles. Those individuals have now been identified (the Health Plan Operations role has been split into two separate roles, with an executive identified to serve in each). Enclosed please find revised Exhibit S, and completed biographical affidavits for Joseph Smith, Pamela Warren and John Rodgers. The biographical affidavits have also been forwarded to the third party vendor for verification and background checks, and the reports will be sent to you directly by the vendor.

Thank you for your assistance, and your continued review of the Form A.

Very Truly Yours,

Robin L. Larmer

cc: Frank C. Miller, Kaiser Foundation Health Plan, Inc.
Shawna M. Sweeney, Group Health Cooperative

Exhibit S

Anticipated Group Health Cooperative Management Changes
Current as of November 10, 2016

GHC Position	Current Incumbent	Change post-Transaction
President and Chief Executive Officer	Scott Armstrong	Susan Mullaney, currently Regional President Designate for Kaiser Foundation Health Plan of Washington, will become Regional President
Executive Vice President and Chief Financial Officer	Linda Breard	Karen Schartman, currently Vice President and Chief Financial Officer for Kaiser Foundation Health Plan of the Northwest, will become Chief Financial Officer
Executive Vice President and Chief Information Officer	Sue Kozik	John Rodgers, currently Executive Director, Application Services Delivery for the Kaiser Permanente Care Delivery Technology Services (CDTS) Organization, will become Vice President and Information Officer
Executive Vice President, Health Plan Division (Health Plan Operations) (this position will be split into two separate positions)	Robert O'Brien	Joseph Smith, currently Vice President, Small Business for Kaiser Foundation Health Plan will become Vice President for Marketing, Sales and Business Development Pamela Warren, currently Vice President, Health Plan Operations for Group Health Cooperative, will become Vice President, Health Plan Service and Administration

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November 16, 2016

Mr. Ronald J. Pastuch, CPA
Holding Company Manager, Company Supervision Division
Washington State Office of the Insurance Commissioner
PO Box 40249
Olympia, WA 98504-0259

Re: ***Proposed Acquisition of Group Health Cooperative by Kaiser Foundation Health Plan of Washington – Fourth Supplement and Amendment to Form A***

Dear Ron:

Thank you for your continued review of Kaiser Foundation Health Plan of Washington's ("*KFHPW*") Form A dated February 29, 2016, and KFHPW's subsequent First, Second and Third Supplements to Form A and Response to RRC's Requests (collectively, the "*Form A*"). KFHPW submits this Fourth Supplement to update certain information in the Form A and to address some of the issues raised in our recent discussions with you and your team.

A. Financial Statements

As a supplement to Form A (Exhibit H), enclosed please find the third quarter 2016 combined financial statements for Kaiser Foundation Health Plan, Inc. ("*KFHP*") and Kaiser Foundation Hospitals ("*KFH*").

In our recent meeting, you asked whether we could provide separate audited financial statements for KFHPW. KFHPW has had no material operations in recent years, and as such, no separate audited financial statements for that entity are available (any financial activity will be reflected in the combined statements). However, KFHPW will provide an audited opening balance sheet for KFHPW after closing of the Transaction, and going forward, will continue to submit all required financial filings.

B. Post-Transaction Consumer Input

KFHPW recognizes the value of community input in establishing policy for Group Health Cooperative ("*GHC*"). Moreover, KFHPW is aware of the statutory requirement that GHC

maintain an OIC-approved process that affords consumers a meaningful role in policy making. RCW 48.46.020(18). As such, KFHPW has made a commitment to establish and maintain a Consumer Advisory Committee to facilitate consumer input.

The Acquisition Agreement between GHC, Group Health Community Foundation ("*GHCF*") and KFHPW ("*Acquisition Agreement*") reflects this commitment, providing in relevant part that KFHPW will "establish a Consumer Advisory Committee in order to afford its enrolled members an opportunity to participate in matters of policy and operation and to promote the effective use of health care services within [GHC], and to suggest ways that the program can better serve its members". See Acquisition Agreement (Form A, Exhibit B, Sec. 5.18). The proposed post-Transaction GHC bylaws also reflect this commitment, by specifically providing for the establishment of the Consumer Advisory Committee (Form A, Exhibit C, Sec. 2.9).

KFHPW also recognizes the value of the input and participation of the special interest group known as the GHC Senior Caucus. As represented in statements made by KFHPW and GHC leaders during the Commissioner's Town Hall meetings and on other occasions, KFHPW will continue to acknowledge the Senior Caucus as a recognized special interest group, consistent with historical GHC practice.

C. Intercompany Guarantee

KFH and KFHP have entered into a guaranty agreement under which they guarantee all of the liabilities, debts and obligations of each other and substantially all of the liabilities, debts and obligations of the other affiliated Kaiser health plans. A copy of the guarantee agreement was submitted in response to RRC's request for information dated August 18, 2016. Kaiser leadership has determined that GHC will participate in and become a party to the guaranty agreement following closing of the Transaction.

D. Intercompany Agreements

As we discussed, KFHPW and GHC intend for certain administrative and other services to be provided to GHC by Kaiser Permanente in order to benefit from efficiencies of scale. Some services will be implemented immediately following closing of the Transaction, and others will be implemented over the course of several months following closing. GHC submitted a proposed Administrative Services Agreement and corresponding Form D on November 2, 2016, and subsequently submitted two additional Intercompany Agreements with Form D filings on November 10, 2016. KFHPW and GHC do not anticipate that they will enter into any additional Intercompany Agreements in the near future, and accordingly, believe that all currently required Form D filings have been submitted. We will follow up with you to address any questions you may have about the pending submissions.

E. Post-Transaction Governance Structure

We understand that OIC would like the current eligibility criteria for GHC board members, as described in the Form A, to be retained for a period of time following closing of the Transaction. As we discussed, there are no present plans to adjust the criteria, and we do not anticipate that the criteria will be adjusted in the immediate future. [1]

However, it is possible that adjustment of the eligibility criteria may be warranted (and perhaps required by statute) in the more distant future. For example, it may be appropriate to recruit and seat board members to represent certain geographic regions as GHC's service area expands to include those regions. Accordingly, we propose that the current eligibility criteria be retained for a minimum period of two years, after which time the criteria may be adjusted if and to the extent warranted.

F. Holding Company Name Change

Shortly following closing of the Transaction, the names of GHC and Group Health Options, Inc. will be changed to Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc., respectively. We are working with Gayle Pasero to obtain, on or around February 15, 2017, amended Certificates of Registration. Prior to these name changes, the name of (current) Kaiser Foundation Health Plan of Washington will be changed to KFHPW Holdings.

Again, thank you for your continued review and efforts in connection with the Form A. If you have questions or require additional information, please feel free to contact me at any time.

Very Truly Yours,

Robin L. Larmer

Cc: Frank C. Miller, Kaiser Foundation Health Plan, Inc.
Shawna M. Sweeney, Group Health Cooperative

[1] We note that any such adjustments made in the future would be limited by the statutory requirement that at least 1/3 of the members of the governing body of an HMO shall consist of consumers who are substantially representative of the enrolled population of the HMO. RCW 48.46.070(1). KFHPW will continue to comply with this requirement, as well as the applicable requirements of the Insurer Holding Company Act. RCW 48.31B.030(4).

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

Combined Financial Statements

For the nine months ended September 30, 2016 and 2015

(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

September 30, 2016 and December 31, 2015

(In millions)

Assets	2016	2015
Current assets:		
Cash and cash equivalents	$ 260	$ 210
Current investments	9,228	6,554
Securities lending collateral	875	1,068
Broker receivables	493	816
Due from associated medical groups	7	5
Accounts receivable - net	1,905	1,966
Inventories and other current assets	1,485	1,422
Total current assets	14,253	12,041
Noncurrent investments	26,439	26,189
Land, buildings, equipment, and software - net	23,926	23,782
Other long-term assets	610	585
Total assets	$ 65,228	$ 62,597
Liabilities and Net Worth		
Current liabilities:		
Accounts payable and accrued expenses	$ 3,216	$ 2,977
Medical claims payable	1,813	1,750
Due to associated medical groups	673	784
Payroll and related charges	1,992	1,694
Medicare payments received in advance	1,223	—
Securities lending payable	875	1,068
Broker payables	863	1,160
Long-term debt subject to short-term remarketing arrangements - net	785	732
Other current debt	1,903	775
Other current liabilities	1,736	2,027
Total current liabilities	15,079	12,967
Long-term debt	4,755	6,060
Physicians' retirement plan liability	6,056	5,730
Pension and other retirement liabilities	8,697	10,525
Other long-term liabilities	2,458	2,418
Total liabilities	37,045	37,700
Net worth	28,183	24,897
Total liabilities and net worth	$ 65,228	$ 62,597

See accompanying notes to combined financial statements.

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

Combined Statements of Operations and Changes in Net Worth

Nine months ended September 30, 2016 and 2015

(In millions)

	2016	2015
Revenues:		
Members' dues	$ 32,536	$ 30,692
Medicare	11,425	10,861
Copays, deductibles, fees, and other	4,292	4,075
Total operating revenues	48,253	45,628
Expenses:		
Medical services	22,585	20,675
Hospital services	12,270	12,115
Outpatient pharmacy and optical services	5,512	5,236
Other benefit costs	3,100	2,876
Total medical and hospital services	43,467	40,902
Health Plan administration	2,922	2,862
Total operating expenses	46,389	43,764
Operating income	1,864	1,864
Other income and expense:		
Investment income - net	604	214
Interest expense	(133)	(143)
Total other income and expense	471	71
Net income	2,335	1,935
Change in pension and other retirement liability charges	(36)	527
Change in net unrealized gains on investments	991	(962)
Change in noncontrolling interest	(4)	4
Change in net worth	3,286	1,504
Net worth at beginning of year	24,897	20,827
Net worth at end of period	$ 28,183	$ 22,331

See accompanying notes to combined financial statements.

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

Quarterly Combined Statements of Operations and Changes in Net Worth

Three months ended September 30, 2016 and 2015

(In millions)

	2016	2015
Revenues:		
Members' dues	$ 10,907	$ 10,256
Medicare	3,826	3,629
Copays, deductibles, fees, and other	1,421	1,449
Total operating revenues	16,154	15,334
Expenses:		
Medical services	7,357	7,045
Hospital services	4,262	4,106
Outpatient pharmacy and optical services	1,818	1,818
Other benefit costs	1,078	1,057
Total medical and hospital services	14,515	14,026
Health Plan administration	967	945
Total operating expenses	15,482	14,971
Operating income	672	363
Other income and expense:		
Investment income (loss) - net	497	(425)
Interest expense	(45)	(53)
Total other income and expense	452	(478)
Net income	1,124	(115)
Change in pension and other retirement liability charges	3	(86)
Change in net unrealized gains on investments	397	(793)
Change in noncontrolling interest	(1)	(4)
Change in net worth	1,523	(998)
Net worth at beginning of quarter	26,660	23,329
Net worth at end of quarter	$ 28,183	$ 22,331

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

Nine months ended September 30, 2016 and 2015

(In millions)

	2016	2015
Cash flows from operating activities:		
Net income	$ 2,335	$ 1,935
Adjustments to reconcile net income to net cash provided from operating activities:		
Depreciation and software amortization	1,700	1,607
Other amortization	(55)	1
Loss (gain) recognized on investments - net	(245)	106
Loss on land, buildings, equipment, and software - net	11	40
Changes in assets and liabilities:		
Accounts receivable - net	61	(128)
Due from associated medical groups	(2)	(4)
Other assets	(61)	(256)
Accounts payable and accrued expenses	305	(380)
Medical claims payable	63	261
Due to associated medical groups	(182)	(92)
Payroll and related charges	(96)	(110)
Medicare payments received in advance	1,223	—
Pension and other retirement liabilities	(1,905)	(584)
Other liabilities	196	360
Net cash provided from operating activities	3,348	2,756
Cash flows from investing activities:		
Additions to land, buildings, equipment, and software	(1,906)	(1,899)
Proceeds from sales of land, buildings, and equipment	5	4
Proceeds from investments	28,686	26,437
Investment purchases	(30,334)	(27,720)
Decrease in securities lending collateral	193	369
Broker receivables / payables	26	(41)
Issuance of notes receivable	(116)	(97)
Prepayment and repayment of notes receivable	75	85
Other investing	(40)	(26)
Physicians' retirement plan liability	367	393
Net cash used in investing activities	(3,044)	(2,495)
Cash flows from financing activities:		
Issuance of debt	2,590	1,124
Prepayment and repayment of debt	(2,647)	(1,142)
Increase (decrease) in securities lending payable	(193)	(369)
Change in noncontrolling interest	(4)	4
Net cash used in financing activities	(254)	(383)
Net change in cash and cash equivalents	50	(122)
Cash and cash equivalents at beginning of year	210	288
Cash and cash equivalents at end of the period	$ 260	$ 166
Supplemental cash flows disclosure:		
Cash paid for interest - net of capitalized amounts	$ 133	$ 133

See accompanying notes to combined financial statements.

(1) Description of Business

The accompanying combined financial statements include Kaiser Foundation Health Plan, Inc. and Subsidiaries (Health Plans) and Kaiser Foundation Hospitals and Subsidiaries (Hospitals). Health Plans and Hospitals are primarily not-for-profit corporations whose capital is available for charitable, educational, research, and related purposes. Health Plans are primarily health maintenance organizations and are generally exempt from federal and state income taxes. Membership at September 30, 2016 and December 31, 2015 was 10.6 million and 10.2 million, respectively. At September 30, 2016 and December 31, 2015, the percentage of enrolled membership in California was approximately 77% and 78%, respectively. The principal operating subsidiary of Kaiser Foundation Hospitals is Kaiser Hospital Asset Management, Inc. (KHAM). The principal operating subsidiaries of Kaiser Foundation Health Plan, Inc. (Health Plan, Inc.) are:

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

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

At both September 30, 2016 and December 31, 2015, the percentage of Health Plans' and Hospitals' total labor force covered under collective bargaining agreements was approximately 70%. At September 30, 2016, approximately 10% of the workforce was covered under collective bargaining agreements that were scheduled to expire within one year. At September 30, 2016, none of the workforce was working under an expired agreement, and approximately 1% of the workforce was in a new bargaining unit that was negotiating an agreement.

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

For the year ended December 31, 2015, Community Benefit expenditures (at cost, net of approximately $2.6 billion of related revenues) were $2.1 billion, representing 3.5% of operating revenue. The calculation of

Community Benefit expenditures is based on Health Plans' and Hospitals' direct and indirect costs and the services provided by Health Plans and Hospitals under Community Benefit programs.

(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 November 14, 2016, which is the date that these combined financial statements were issued.

(b) Cash and Cash Equivalents

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

(c) Investments

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

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

- Substantially all investments are managed by outside investment managers who do not need Health Plans' or Hospitals' management preapproval for sales; therefore, substantially all declines in value below cost are recognized as impairment that is other-than-temporary.

- For other securities, losses are recognized for known matters, such as bankruptcies, regardless of ownership period, and investments that have been continuously below book value for an extended period of time are evaluated for impairment that is other-than-temporary.

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

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

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

(d) Securities Lending Collateral and Payable

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

(e) Broker Receivables and Payables

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

(f) Inventory

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

(g) Land, Buildings, Equipment, and Software

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

Buildings and equipment are depreciated on a straight-line basis over the estimated useful lives of the various classes of assets, generally ranging from 3 to 33 years.

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

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

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

(h) Medical Claims Payable

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

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

(i) Due to Associated Medical Groups

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

(j) Self-Insured Risks

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

(k) Premium Deficiency Reserves

Premium deficiency reserves and the related expense are recognized when it is probable that expected future health care and maintenance costs under a group of existing contracts will exceed anticipated future premiums and reinsurance recoveries over the contract period. If applicable, premium deficiency reserves extending beyond one year are shown as a long-term liability. Expected investment income and interest expense are included in the calculation of premium deficiency reserves, as appropriate. The level at which contracts are grouped for evaluation purposes is generally by geographic region. The methods for making such estimates and for establishing the resulting reserves are reviewed and updated, and any resulting adjustments are reflected in current operations. At September 30, 2016 and December 31, 2015, premium deficiency reserves were $32 million and $45 million, respectively. Given the inherent variability of such estimates, the actual liability could differ significantly from the calculated amount.

(l) Derivative Financial Instruments

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

are included in investment income - net and settlement costs are recorded as interest expense or investment income - net.

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

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

(m) Revenue Recognition

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

Health Plans estimates accrued retrospective premium adjustments for certain group health insurance contracts based on claims experience and the provisions of the contract. Health Plans records accrued retrospective premiums as an adjustment to members' dues. For the nine months ended September 30, 2016 and 2015, the amount of premiums written by Health Plans subject to the retrospective rating feature were $759 million and $619 million, respectively. During the nine months ended September 30, 2016 and 2015, revenue derived under these contracts was 2.3% and 2.0%, respectively, of total members' dues. During the nine months ended September 30, 2016 and 2015, retrospective dues adjustments were $(3.2) million and $(13.1) million, respectively.

Health Plans participate in certain commercial contracts, which include provisions 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 nine months ended September 30, 2016 and 2015, dues subject to these private risk adjustment arrangements comprise 8.8% and 8.5%, respectively, of total dues premiums. For the nine months ended September 30, 2016 and 2015, $21 million and $73 million, respectively, have been recorded as reductions to revenue for these private 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 the 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 capitated contracts with third parties. Third party Medicaid revenue is included in copays, deductibles, fees, and other revenue in the statement of operations. For the nine months ended September 30, 2016 and 2015, revenues related to these arrangements were $1.1 billion and $979 million, respectively.

(n) Pension and Other Postretirement Benefits

Health Plans' and Hospitals' defined benefit pension and other postretirement benefit plans are actuarially evaluated and involve various assumptions. Critical assumptions include the discount rate and the expected rate of return on plan assets, and the rate of increase for health care costs (for postretirement benefit plans other than pension), which are important elements of expense and/or liability measurement. Other assumptions involve demographic factors such as retirement age, mortality, turnover, and the rate of compensation increases. Health Plans and Hospitals evaluate assumptions annually, or when significant plan amendments occur, and modify them as appropriate.

Pension and other postretirement costs are allocated over the service period of the employees in the plans.

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

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

(o) Donations and Grants Made or Received

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

(p) Use of Estimates

The preparation of these combined financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts. Allowance for uncollectible accounts receivable; estimated fair value of investments; Medicare revenue accruals; Medicare reserves; incurred but not reported medical claims payable; physicians' retirement plan liabilities; pension and other retirement liabilities; premium deficiency reserves; self-insured professional liabilities; self-insured general and workers' compensation liabilities; land, buildings, equipment, and software impairment and useful lives; investment impairment; and certain amounts accrued related to the PPACA Reinsurance, Risk Adjustment, and Risk Corridors Programs represent significant estimates. Actual results could differ materially from those estimates. As occurs from time to time, negotiations with labor partners may result in changes to compensation and benefits. These changes are reflected in the financial statements as appropriate when agreements are finalized.

(q) Reclassifications

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

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

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

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

The Reinsurance Program is temporary, and provides for partial reimbursement of certain high cost claims for non-grandfathered individual members, beginning in 2014 and continuing through 2016. As described in the *Medical Claims Payable* note, certain amounts have been recorded in 2016 and 2015 as expected claims reimbursements under this program. For the nine months ended September 30, 2016 and 2015, Health Plans has recorded $103 million and $224 million, respectively, for estimated recoveries from the Reinsurance Program. For the nine months ended September 30, 2016 and 2015, Health Plans has recorded $164 million and $257 million, respectively, of Reinsurance fees.

The Risk Adjustment Program is permanent, and provides for retrospective adjustment of revenue for non-grandfathered individual and small group market plans, whether inside or outside PPACA exchanges. The Risk Adjustment Program is designed such that payments to plans with higher relative risk are funded by transfers from plans with lower relative risk. For the nine months ended September 30, 2016 and 2015, Health Plans has recorded $(484) million and $39 million, respectively, in net revenue increases/(reductions) related to the Risk Adjustment Program.

The Risk Corridors Program is temporary, beginning in 2014 and continuing through 2016. This program provides for gains and losses on the individual and small group market plans. For the nine months ended September 30, 2016 and 2015, Health Plans has recorded $5 million and $(12) million, respectively, in net revenue increases/(reductions) related to the Risk Corridors Program.

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

	At September 30, 2016	At December 31, 2015
Reinsurance recoveries	$ 107	$ 229
Risk Adjustment settlements	(284)	(39)
Risk Corridors settlements	(1)	(5)
Total	$ (178)	$ 185

At September 30, 2016, net receivables (payables) for Reinsurance recoveries, Risk Adjustment settlements, and Risk Corridors settlements of $79 million, $(295) million, and $0 million, respectively, were related to the 2016 Programs. At September 30, 2016, net receivables (payables) for Reinsurance recoveries, Risk Adjustment settlements, and Risk Corridors settlements of $28 million, $10 million, and $(1) million, respectively, were related to the 2015 Programs. At September 30, 2016, net receivables for Reinsurance recoveries, Risk Adjustment settlements, and Risk Corridors settlements of $0 million, $1 million, and $0 million, respectively, were related to the 2014 Programs.

At December 31, 2015, net receivables (payables) for Reinsurance recoveries, Risk Adjustment settlements, and Risk Corridors settlements of $229 million, $(50) million, and $(6) million, respectively, were related to the 2015 Programs. At December 31, 2015, net receivables for Reinsurance recoveries, Risk Adjustment settlements, and Risk Corridors settlements of $0 million, $11 million, and $1 million, respectively, were related to the 2014 Programs.

(s) Recently Issued Accounting Standards

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Updates (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*. Early application is permitted but not earlier than the original effective date of January 1, 2017. The standard permits the use of either the retrospective or cumulative effect transition method. Management is evaluating the effect that ASU No. 2014-09 will have on its combined financial statements and related disclosures. Management has not yet selected a transition method nor has it determined the effect of the standard on its ongoing financial reporting.

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

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

In April 2015, the FASB issued ASU No. 2015-05 *Intangibles - Goodwill and Other - Internal-Use Software (Subtopic 350-40)*. The amendments in this update provide guidance to customers about whether a cloud computing arrangement includes a software license. The new standard was adopted by Health Plans and Hospitals in 2016. Management has selected the prospective transition method. The adoption of this standard did not have a significant effect on the combined financial statements and related disclosures.

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

In January 2016, the FASB issued ASU No. 2016-01 *Financial Instruments - Overall (Subtopic 825-10)*. The standard requires entities to measure equity investments that are not accounted for under the equity method or do not result in consolidation 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, as opposed to change in net worth as currently reflected, 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. Management is evaluating the effect that ASU No. 2016-02 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 2016, the FASB issued ASU No. 2016-07 *Investments - Equity Method and Joint Ventures (Topic 323).* The amendments in this update eliminate the requirement to retroactively adopt the equity method of accounting when an investment qualifies for the use of the equity method as a result of an increase in the level of ownership or degree of influence. The new standard is effective for Health Plans and Hospitals on January 1, 2017. Early application is permitted. The standard requires the use of the prospective transition method. Management is evaluating the effect that ASU No. 2016-07 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 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 is evaluating the effect that ASU No. 2016-13 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. 2016-14 *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-profit entities. The new standard is effective for Health Plans and Hospitals on January 1, 2018. Early application is permitted. The standard requires the use of the retrospective transition method. Management is evaluating the effect that ASU No. 2016-14 will have on its combined financial statements and related disclosures. Management has not determined the effect of the standard on its ongoing financial reporting.

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

(3) Group Health Cooperative and Maui Health System Agreements

In December 2015, Kaiser Foundation Health Plan of Washington (KFHPW), a subsidiary of Health Plan Inc., entered into a definitive agreement to acquire and become the sole member of Group Health Cooperative (Group Health), a Washington nonprofit corporation and licensed health maintenance organization, for $1.8 billion. The agreement also requires $1 billion of capital spending and key investments in infrastructure and other improvements, subject to review and approval under KFHPW's standard capital approval process; and KFHPW expects to make $800 million of community benefit contributions over a 10 year period. Group Health and Group Health Permanente, P.C. (GHP), a Washington professional services corporation, have an existing exclusive arrangement for the provision of physician and certain other medical services to Group Health enrollees. As part of the Group Health transaction, KFHPW and GHP have reached an agreement, contingent on the successful completion of the Group Health transaction, providing the terms and conditions under which GHP will continue to provide such services to Group Health enrollees after the close of the Group Health transaction, including payments to GHP of up to $200 million. In March 2016, the voting membership of Group Health formally approved the proposed acquisition. The transactions are in the process of regulatory approval and are expected to close in 2017. Cash of $2 billion was transferred in 2015 from Hospitals to KFHPW and is restricted for purposes of completing the transactions. At September 30, 2016, this restricted asset is included in current investments in the combined financial statements.

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. All 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 September 30, 2016 and December 31, 2015, the carrying amount of long-term debt totaled $5.6 billion and $6.9 billion, respectively. At September 30, 2016 and December 31, 2015, the estimated fair value of long-term debt was approximately $5.9 billion and $7.1 billion, respectively.

At September 30, 2016 and December 31, 2015, Health Plans and Hospitals held derivative financial instruments including interest rate swaps, as well as futures, swaps, and forwards held within investment portfolios. The estimated fair values of derivative instruments were determined using level 2 inputs, including available market information and valuation methodologies, primarily discounted cash flows. Additional description and the fair value of derivative instruments are contained in the *Derivative Instruments* note.

(5) Investments

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

At September 30, 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	$ 34	$ —	$ —	$ 34
Debt securities issued by the U.S. government	—	3,054	—	3,054
Debt securities issued by U.S. government agencies and corporations	—	66	—	66
Debt securities issued by U.S. states and political subdivisions of states	—	66	—	66
Foreign government debt securities	—	84	—	84
U.S. corporate debt securities	—	2,397	—	2,397
Foreign corporate debt securities	—	1,080	—	1,080
U.S. agency mortgage-backed securities	—	734	—	734
Non-U.S. agency mortgage-backed securities	—	268	—	268
Other asset-backed securities	—	670	—	670
Short-term investment funds	—	775	—	775
Total	$ 34	$ 9,194	$ —	$ 9,228

At September 30, 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	$ 4,072	$ 9	$ —	$ 4,081
Foreign equity securities	3,109	1,477	—	4,586
Global equity funds	—	716	—	716
Debt securities issued by the U.S. government	—	1,220	—	1,220
Debt securities issued by U.S. government agencies and corporations	—	111	—	111
Debt securities issued by U.S. states and political subdivisions of states	—	197	—	197
Foreign government debt securities	—	1,214	—	1,214
U.S. corporate debt securities	—	3,606	—	3,606
Foreign corporate debt securities	—	1,432	—	1,432
U.S. agency mortgage-backed securities	—	642	—	642
Non-U.S. agency mortgage-backed securities	—	234	9	243
Other asset-backed securities	—	221	—	221
Short-term investment funds	—	675	—	675
Other	93	495	1	589
Alternative investments:				
Absolute return	—	1,183	1,009	2,192
Private equity	—	—	3,833	3,833
Risk parity	—	—	881	881
Total	$ 7,274	$ 13,432	$ 5,733	$ 26,439

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

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

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

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

At September 30, 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	$ 3,412	$ 703	$ —	$ 4,115
Foreign equity securities	3,843	743	—	4,586
Global equity funds	483	233	—	716
Debt securities issued by the U.S. government	4,232	42	—	4,274
Debt securities issued by U.S. government agencies and corporations	165	12	—	177
Debt securities issued by U.S. states and political subdivisions of states	217	46	—	263
Foreign government debt securities	1,182	116	—	1,298
U.S. corporate debt securities	5,593	410	—	6,003
Foreign corporate debt securities	2,387	125	—	2,512
U.S. agency mortgage-backed securities	1,352	24	—	1,376
Non-U.S. agency mortgage-backed securities	499	12	—	511
Other asset-backed securities	881	10	—	891
Short-term investment funds	1,450	—	—	1,450
Other	543	46	—	589
Total	$ 26,239	$ 2,522	$ —	$ 28,761

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

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

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

	At September 30, 2016		At December 31, 2015	
	Amortized cost	Fair value	Amortized cost	Fair value
Due in one year or less	$ 2,438	$ 2,444	$ 3,585	$ 3,587
Due after one year through five years	7,476	7,626	5,852	5,881
Due after five years through ten years	2,530	2,693	2,536	2,567
Due after ten years	3,325	3,803	3,141	3,279
U.S. agency mortgage-backed securities	1,352	1,376	1,311	1,323
Non-U.S. agency mortgage-backed securities	499	511	534	541
Other asset-backed securities	881	891	782	789
Total	$ 18,501	$ 19,344	$ 17,741	$ 17,967

For the nine months ended September 30, 2016, the reconciliation of investments with fair value measurements using significant unobservable inputs (level 3) was as follows (in millions):

	Debt securities	Alternative investments	Total
Beginning balance	$ 12	$ 5,005	$ 5,017
Transfers out of level 3	—	—	—
Total net losses:			
Realized	—	90	90
Unrealized	—	—	—
Purchases	—	1,101	1,101
Sales	—	(473)	(473)
Settlements	(2)	—	(2)
Ending balance	$ 10	$ 5,723	$ 5,733
Total realized and unrealized year-to-date net gains related to assets held at September 30, 2016	$ —	$ 83	83

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

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

Transfers between fair value input levels, if any, are recorded at the end of the reporting period. Transfers between fair value input levels occur when valuation inputs used to record or disclose assets or liabilities change from one level of the valuation hierarchy to another. During the nine months ended September 30, 2016 and the year ended December 31, 2015, there were no transfers between assets with inputs with quoted

prices in active markets for identical assets (level 1) and assets with inputs with significant other observable inputs (level 2).

Investments include specific funds held in trust accounts related to collateral requirements for certain reinsurance agreements. At September 30, 2016 and December 31, 2015, the values of these funds were $47 million and $53 million, respectively.

Absolute return investments use advanced investment strategies, including derivatives, to generate positive long-term risk adjusted returns. Private equity investments consist of funds that make direct investments in private companies. Risk parity funds use risk as the primary factor to allocate investments among asset classes. Management meets with alternative investment fund managers periodically to assess portfolio performance and reporting and exercises oversight over fund managers. At September 30, 2016, Hospitals had original commitments related to alternative investments of $7.5 billion, of which $4.5 billion was invested, leaving $3.0 billion of remaining commitments. At December 31, 2015, Hospitals had original commitments related to alternative investments of $6.7 billion, of which $3.7 billion was invested, leaving $3.0 billion of remaining commitments.

For the nine months ended September 30, investment income - net was comprised of the following (in millions):

	2016	2015
Other-than-temporary impairment	$ (391)	$ (1,089)
Recognized gains	835	1,123
Recognized losses	(242)	(233)
Income from equity method alternative investments	345	122
Interest, dividends, and other income - net	603	548
Derivative income (loss)	(226)	69
Total investment income - net	924	540
Less investment income included in operating income	(320)	(326)
Investment income - net	$ 604	$ 214

For the nine months ended September 30, 2016 and 2015, Health Plans and Hospitals recorded impairment of certain investments in accordance with the policy described in the *Summary of Significant Accounting Policies - Investments* note. During the nine months ended September 30, 2016 and 2015, there was $2 million and $1 million, respectively, of impairment of alternative investments.

Absolute return, risk parity, and private equity investments include redemption restrictions. Absolute return and risk parity investments require 10 to 90 day written notice of intent to withdraw and are often subject to the approval and capital requirements of the fund manager. Absolute return and risk parity investments of $829 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 $1.4 billion are redeemable between 10 and 30 days. Equity investment funds of $299 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 September 30, 2016 and December 31, 2015, Health Plans and Hospitals had 11 agreements to manage interest rate fluctuations (Interest Rate Swaps) with a total notional amount of $1.2 billion. At September 30, 2016 and December 31, 2015, the fair values of these agreements were $(351) million and $(274) million, respectively, and were recorded in other long-term liabilities. For the nine months ended September 30, 2016 and 2015, Health Plans and Hospitals recorded $25 million and $26 million, respectively, in interest expense relating to the Interest Rate Swaps. For the nine months ended September 30, 2016 and 2015, net changes in fair values totaled $(77) million and $(21) 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 September 30, 2016 and December 31, 2015, no collateral was required to be posted by either Health Plans and Hospitals or the counterparties.

(b) Derivatives Held in Investment Portfolios

At September 30, 2016 and December 31, 2015, Health Plans' and Hospitals' portfolio managers held $(33) million and $(3) million, respectively, of futures, forwards, options, and swaps to attempt to protect investments against volatility. For the nine months ended September 30, 2016 and 2015, net changes in fair values totaled $(26) million and $(16) million, respectively, and were recorded in investment income - net. For the nine months ended September 30, 2016 and 2015, gains (losses) resulting from derivative settlements totaled $(123) million and $106 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 nine months ended September 30, 2016	2015
Interest rate swaps - related to debt	Investment income - net	$ (77)	$ (21)
Interest rate swaps - other	Investment income - net	(26)	(7)
Options, rights, and warrants	Investment income - net	(1)	16
Futures and forwards	Investment income - net	1	(25)
		$ (103)	$ (37)

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 nine months ended September 30, 2016	2015
Interest rate swaps - related to debt	Interest expense	$ (25)	$ (26)
Interest rate swaps - other	Investment income - net	(73)	(33)
Futures and forwards	Investment income - net	(64)	139
Options, rights, and warrants	Investment income - net	14	—
		$ (148)	$ 80

Information on Fair Value of Derivative Instruments - Assets

(In millions)

Derivatives not designated as hedging instruments	Balance sheet category	Fair value at September 30, 2016	Fair value at December 31, 2015
Interest rate swaps - other	Noncurrent investments	18	13
Futures and forwards	Noncurrent investments	31	33
Options, rights, and warrants	Noncurrent investments	3	1
		$ 52	$ 47

Information on Fair Value of Derivative Instruments - Liabilities

(In millions)

Derivatives not designated as hedging instruments	Balance sheet category	Fair value at September 30, 2016	Fair value at December 31, 2015
Interest rate swaps - related to debt	Other long-term liabilities	$ 351	$ 274
Interest rate swaps - other	Other long-term liabilities	53	22
Futures and forwards	Other long-term liabilities	28	25
Options, rights, and warrants	Other long-term liabilities	4	3
		$ 436	$ 324

(7) Accounts Receivable - net

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

	At September 30, 2016	At December 31, 2015
Members' dues	$ 714	$ 709
Patient services	417	390
Medicare	427	317
Reinsurance recoveries	107	231
Risk Adjustment receivables	24	66
Other	403	399
	2,092	2,112
Allowances for bad debt	(187)	(146)
Total	$ 1,905	$ 1,966

(8) Inventories and Other Current Assets

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

	At September 30, 2016	At December 31, 2015
Inventories - net	$ 858	$ 871
Prepaid expenses	438	481
Other	189	70
Total	$ 1,485	$ 1,422

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

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

	At September 30, 2016	At December 31, 2015
Land	$ 1,842	$ 1,821
Buildings and improvements	31,661	30,761
Furniture, equipment, and software	11,411	10,791
Construction and software development in progress	2,034	1,920
	46,948	45,293
Accumulated depreciation and amortization	(23,022)	(21,511)
Total	$ 23,926	$ 23,782

Health Plans and Hospitals capitalize interest costs on borrowings incurred during the construction, upgrade, or development of qualifying assets. Capitalized interest is added to the cost of the underlying assets and is depreciated or amortized over the useful lives of the assets. During the nine months ended September 30, 2016 and 2015, Health Plans and Hospitals capitalized $22 million and $20 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 September 30, 2016 and December 31, 2015, the liability for asset retirement obligations was $84 million and $85 million, respectively. During both the nine months ended September 30, 2016 and 2015, amortization and other adjustments of the associated assets totaled $1 million. At September 30, 2016 and December 31, 2015, the unamortized asset related to these retirement obligations was $11 million and $13 million, respectively.

(10) Medical Claims Payable

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

	At September 30, 2016	At December 31, 2015
Balances at January 1	$ 1,750	$ 1,393
Incurred related to:		
Current year	6,867	8,342
Prior years	(155)	(33)
Total incurred	6,712	8,309
Paid related to:		
Current year	5,224	6,795
Prior years	1,425	1,157
Total paid	6,649	7,952
Balances	$ 1,813	$ 1,750

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

(11) Other Liabilities

Other current liabilities were as follows (in millions):

	At September 30, 2016	At December 31, 2015
Self-insured risks	$ 394	$ 393
Dues collected in advance	712	628
Medicare liabilities	34	45
Physicians' retirement plan liability	171	171
TBA commitments	89	149
Other	730	641
Total	$ 2,130	$ 2,027

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

	At September 30, 2016	At December 31, 2015
Self-insured risks	$ 1,484	$ 1,500
Derivatives liability	436	324
Due to associated medical groups	219	289
Other	319	305
Total	$ 2,458	$ 2,418

(12) Debt

Debt was as follows (in millions):

	At September 30, 2016	At December 31, 2015
Tax-exempt revenue bonds and taxable bonds and notes:		
0.01% to 2.00% variable rate due through 2052	$ 5,106	$ 4,097
3.60% to 5.25% fixed rate due through 2045	2,330	3,468
Others at various rates due through 2026	7	2
Total	$ 7,443	$ 7,567
Other current debt:		
Commercial paper	$ 1,885	$ 654
Current portion of long-term debt	18	121
Long-term debt subject to short-term remarketing arrangements - net	785	732
Long-term debt classified as a long-term liability	4,755	6,060
Total	$ 7,443	$ 7,567

At September 30, 2016 and December 31, 2015, repurchase of variable rate bonds totaling $3.2 billion and $3.4 billion, respectively, may be required at earlier than stated maturity. These bonds may be remarketed rather than repurchased. Health Plans and Hospitals have provided self liquidity for the variable rate demand bonds with put options. Additionally, at both September 30, 2016 and December 31, 2015, management had the ability to finance the acquisition of up to $2.4 billion of any unremarketed bonds that are put, using available credit facilities. At September 30, 2016 and December 31, 2015, $785 million and $732 million, respectively, of these variable rate demand bonds were classified in current liabilities. At September 30, 2016 and December 31, 2015, these amounts were net of available long-term credit facilities of $2.4 billion.

At September 30, 2016 and December 31, 2015, $32 million and $52 million, respectively, of the above tax-exempt fixed-rate revenue bonds represented a net unamortized premium balance. At September 30,

2016 and December 31, 2015, $(23) million and $(29) million, respectively, of unamortized debt issuance cost was presented within long-term debt.

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

	At September 30, 2016
2016	$ 1,885
2017	18
2018	18
2019	247
2020	18
Thereafter	5,248
Total	$ 7,434

At September 30, 2016, Hospitals had certain bonds that require mandatory tender by the holder on a date certain in the amount of $275 million in 2017. Hospitals intends to remarket these bonds until final maturity of the bonds.

Credit Facility

Hospitals' credit facility of $2.4 billion terminates in September 2021. Various interest rate options are available under this facility. Any revolving borrowings mature on the termination date. Hospitals pays facility fees, which range from 0.05% to 0.15% per annum, depending upon Hospitals' long-term senior unsecured debt rating. At September 30, 2016, the facility fee was at an annual rate of 0.06%. At September 30, 2016 and December 31, 2015, no amounts were outstanding under this credit facility.

Hospitals' revolving credit facility contains financial covenants. 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 September 30, 2016 and December 31, 2015, commercial paper of $1.9 billion and $654 million, respectively, was outstanding under this program and is included within other current debt.

(13) Pension Plans

(a) Defined Benefit Plan

Health Plans and Hospitals have a defined benefit pension plan (Plan) covering substantially all their employees. Benefits are based on age at retirement, years of credited service, and average compensation for a specified period prior to retirement. Contributions are intended to provide not only for benefits attributed to service to date but also for those expected to be earned in the future.

For financial reporting purposes, the projected unit credit method is used. At September 30, 2016 and December 31, 2015, substantially all pension fund assets were held in a group trust. At September 30, 2016 and December 31, 2015, the trust's assets were invested primarily in fixed-income and equity securities, with approximately 21% and 22%, respectively, of trust assets, net of liabilities, invested in alternative investments.

At December 31, 2015, the funded status of the Plan was as follows (in millions):

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

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

The accrued pension plan liability at December 31, 2015 and the change through September 30, 2016 are as follows (in millions):

Accrued pension plan liability at December 31, 2015	$	6,387
Provision		780
Plan contributions		(1,731)
Plan amendments		—
Accrued pension plan liability at September 30, 2016		5,436
Less: current portion		—
Long-term portion of accrued pension liability at September 30, 2016	$	5,436

For the nine months ended September 30, pension expense was as follows (in millions):

	2016	2015
Service cost	$ 809	$ 847
Interest cost	579	531
Expected return on plan assets	(608)	(509)
Amortization of net actuarial loss	157	289
Amortization of prior service cost	11	7
Net pension expense	948	1,165
Other changes in plan assets and PBO recognized in net worth:		
Prior service cost	—	118
Amortization of net actuarial loss	(157)	(289)
Amortization of prior service cost	(11)	(7)
Total recognized in net worth	(168)	(178)
Total recognized in net periodic benefit cost and net worth	$ 780	$ 987

During 2016, $210 million and $15 million in estimated net actuarial loss and prior service cost, respectively, will be amortized from net worth into net pension expense.

Actuarial assumptions used were as follows:

	2016	2015
Weighted average discount rate at January 1 for calculating pension expense	4.70%	5.00%
Weighted average discount rate for calculating December 31 PBO	N/A	4.70%
Weighted average salary scale for calculating pension expense	4.20%	4.20%
Weighted average salary scale for calculating December 31 PBO	N/A	4.20%
Expected long-term rate of return on plan assets for calculating pension expense	7.25%	7.25%

During 2016, management expects to contribute approximately $1.7 billion to the Plan.

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

2016	$ 648
2017	721
2018	809
2019	892
2020	983
2021 - 2025	5,997

Explanation of Investment Strategies and Policies

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

Capital Market Assumption Methodology

To determine the long-term rate of return assumption for plan assets, management incorporates historical relationships among the various asset classes and subclasses to be accessed over the

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

At September 30, 2016, the estimated fair value of total pension trust assets - net by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
Assets:				
Cash and cash equivalents	$ 152	$ 1,681	$ —	$ 1,833
Broker receivables	—	542	—	542
Securities lending collateral	—	1,273	—	1,273
U.S. equity securities	5,174	510	—	5,684
Foreign equity securities	4,713	1,900	—	6,613
Global equity funds	—	254	—	254
Debt securities issued by the U.S. government	—	1,080	—	1,080
Debt securities issued by U.S. government agencies and corporations	—	67	—	67
Debt securities issued by U.S. states and political subdivisions of states	—	221	—	221
Foreign government debt securities	—	525	—	525
U.S. corporate debt securities	—	4,177	—	4,177
Non-U.S. corporate debt securities	—	1,106	—	1,106
U.S. agency mortgage-backed securities	—	195	—	195
Non-U.S. agency mortgage-backed securities	—	48	—	48
Other	1	640	—	641
Alternative investments:				
Absolute return	—	802	1,199	2,001
Private equity	—	—	2,946	2,946
Risk parity	—	—	640	640
Total assets	10,040	15,021	4,785	29,846
Liabilities:				
Broker payables	—	1,160	—	1,160
Securities lending payable	—	1,273	—	1,273
Other liabilities	11	334	—	345
Total liabilities	11	2,767	—	2,778
Fair value of pension trust assets - net	$ 10,029	$ 12,254	$ 4,785	$ 27,068

At September 30, 2016, Health Plans' and Hospitals' share of pension trust assets was 44.8%, or $12.1 billion. The remaining share of pension trust assets is for Medical Groups and a related party associated with Medical Groups.

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

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

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

Reconciliations of alternative investments with fair value measurements using significant unobservable inputs (level 3) were as follows (in millions):

	At September 30, 2016	At December 31, 2015
Beginning balance	$ 4,185	$ 3,103
Transfers into level 3	—	—
Changes related to actual return on plan assets	53	22
Purchases, sales, and settlements - net	547	1,060
Ending balance	$ 4,785	$ 4,785
Total year-to-date net gains related to assets held at end of period	$ 54	$ 21

During the nine months ended September 30, 2016 and 2015, there were no significant transfers of assets with inputs with quoted prices in active markets for identical assets (level 1) and assets with inputs with significant other observable inputs (level 2).

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

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

Alternative investments, which include absolute return, risk parity, and private equity, held in the pension trust are reported at net asset value as a practical expedient for fair value. Absolute return investments use advanced investment strategies, including derivatives, to generate positive long-term risk adjusted returns. Private equity investments consist of funds that make direct investments in private companies. Risk parity funds use risk as the primary factor to allocate investments among asset classes. At September 30, 2016, the trust had original commitments related to alternative investments of $6.4 billion, of which $3.1 billion was invested, leaving $3.3 billion of remaining commitments. At December 31, 2015, the trust had original commitments related to alternative investments of $5.4 billion, of which $2.4 billion was invested, leaving $3.0 billion of remaining commitments.

Absolute return, risk parity, and private equity investments include redemption restrictions. Absolute return and risk parity investments require 10 to 90 day written notice of intent to withdraw and are often subject to the approval and capital requirements of the fund manager. At September 30, 2016, absolute return and risk parity investments of $823 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 $1.6 billion are redeemable between 10 and 30 days. Equity investment funds of $172 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 nine months ended September 30, 2016 and 2015, there were no required employee contributions. For the nine months ended September 30, 2016 and 2015, plan expense, primarily employer contributions, was $191 million and $180 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 nine months ended September 30, 2016 is outlined in the table below. The "EIN/PN" column provides the Employee Identification Number (EIN) and the three-digit plan number (PN), if applicable. Unless otherwise noted, the most recent Pension Protection Act (PPA) zone status available in 2016 and 2015 is for the plan's year-end in 2015 and 2014, respectively. The zone status is based on information that Health Plans and Hospitals obtained from publicly available information provided by the United States Department of Labor.

Among other factors, plans in the red zone are generally less than 65% funded, plans in the yellow zone are between 65% and 80% funded, and plans in the green zone are at least 80% funded. The "FIP/RP Status Pending/Implemented" column indicates plans for which a financial improvement plan (FIP) or a rehabilitation plan (RP) is either pending or has been implemented. The "Health Plans' and Hospitals' Contributions to Plan Exceeded More Than 5% of Total Contributions" columns represent those plans where Health Plans and Hospitals were listed in the plans' Forms 5500 as providing more than 5% of the total contributions for the plan years listed. The last column lists the expiration dates of the collective bargaining agreements to which the plans are subject. There have been no significant changes that affect the comparability of 2016 and 2015 employer expense.

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

Notes to Combined Financial Statements

For the nine months ended September 30, 2016 and 2015

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 September 30, 2016	(in millions) Health Plans' and Hospitals' Contributions September 30, 2015	Surcharge Imposed	Health Plans' and Hospitals' Contributions to Plan Exceeded More Than 5% of Total Contributions [1] 2015	Health Plans' and Hospitals' Contributions to Plan Exceeded More Than 5% of Total Contributions [1] 2014	Expiration Date of Collective Bargaining Agreement
IUOE Stationary Engineers Local 39 Pension Fund	946118939 -001	Green	Green	N/A	$ 8	$ 8	No	Yes	Yes	9/17/2018
Southern California United Food and Commercial Workers Unions and Drug Employers Pension Fund	516029925 -001	Red	Red	Implemented	4	4	Yes	Yes	Yes	2/1/2020
Oregon Retail Employees Pension Trust[2]	936074377 -001	Red	Red	Implemented	3	2	Yes	Yes	Yes	9/30/2018-10/31/2018
Carpenters Pension Trust Fund for Northern California	946050970 -001	Red	Red	Implemented	5	4	No	No	No	6/30/2019
Other	Various	Green	Green		11	10		No	No	12/31/2016-7/7/2019
Other	Various	Yellow	Yellow		3	2		No	No	6/30/2017-6/30/2019
Total Expense					$ 34	$ 30				

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

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

(14) Postretirement Benefits Other than Pensions

(a) Defined Benefit Plan

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

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

At December 31, 2015, the accrued liability for postretirement benefits was as follows (in millions):

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

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

The accrued liability for postretirement benefits at December 31, 2015 and the change through September 30, 2016 are as follows (in millions):

Accrued postretirement benefits liability at December 31, 2015	$	4,138
Provision		219
Plan amendments		4
Plan contributions		(1,000)
Benefits paid or provided		(100)
Accrued postretirement benefits liability at September 30, 2016		3,261
Less: current portion		—
Long-term portion of accrued postretirement benefits liability at September 30, 2016	$	3,261

For the nine months ended September 30, postretirement benefits expense was as follows (in millions):

	2016	2015
Service cost	$ 117	$ 147
Interest cost	177	193
Expected return on plan assets	(75)	(21)
Amortization of net actuarial loss	81	167
Amortization of prior service credit	(323)	(328)
Postretirement benefits expense	(23)	158
Other changes in plan assets and benefit obligations recognized in net worth:		
Net actuarial loss	—	410
Prior service cost (credit)	4	(851)
Amortization of net actuarial loss	(81)	(167)
Amortization of prior service credit	323	328
Total recognized in net worth	246	(280)
Total recognized in net periodic benefit cost and net worth	$ 223	$ (122)

During 2016, $108 million and $(432) million in estimated net actuarial loss and prior service credit, respectively, will be amortized from net worth into postretirement benefits expense.

During the nine months ended September 30, 2016 and 2015, the benefits paid or provided were $100 million and $103 million, respectively. During the nine months ended September 30, 2016 and 2015, there were no participant contributions from active employees.

Actuarial assumptions used were as follows:

	2016	2015
Weighted average discount rate used for calculating non-union plan postretirement benefits expense from January 1 to September 30	4.75%	4.35%
Weighted average discount rate for calculating union plan postretirement benefits expense from January 1 to January 24	4.75%	4.35%
Weighted average discount rate for calculating union plan postretirement benefits expense from January 25 to June 30	4.75%	3.90%
Weighted average discount rate for calculating December 31 accumulated postretirement benefit obligation	N/A	4.75%
Expected long-term rate of return on plan assets for calculating benefits expense	7.00%	7.00%

The following were the assumed health care cost trend rates used to determine the December 31, 2015 benefit obligation and postretirement benefits expense for the nine months ended September 30, 2016 and 2015:

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

A 1% increase in the health care medical trend rate would increase the benefit obligation by $741 million and the service cost plus interest by $61 million. A decrease of 1% in the health care medical trend rate would decrease the benefit obligation by $605 million and the service cost plus interest by $49 million.

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

2016	$ 141
2017	158
2018	177
2019	199
2020	221
2021 - 2025	1,476

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 September 30, 2016, the estimated fair value of retirement benefit trust assets by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
Assets:				
Cash and cash equivalents	$ —	$ 706	$ —	$ 706
Alternative investments:				
Absolute return	—	150	96	246
Risk parity	—	858	668	1,526
Total assets	$ —	$ 1,714	$ 764	$ 2,478

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

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

Reconciliations of alternative investments with fair value measurements using significant unobservable inputs (level 3) were as follows (in millions):

	At September 30, 2016	At December 31, 2015
Beginning balance	$ 340	$ —
Transfers into level 3	—	—
Changes related to actual return on plan assets	32	(10)
Purchases, sales, and settlements - net	392	350
Ending balance	$ 764	$ 340
Total year-to-date net gains (losses) related to assets held at end of period	$ 32	$ (10)

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

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

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

the approval and capital requirements of the fund manager. At September 30, 2016, absolute return and risk parity investments of $496 million are subject to lock-up periods of up to 3 years.

(b) Multi-Employer Plans

Health Plans and Hospitals participate in multi-employer union-administered retiree medical health and welfare plans that provide benefits to some union employees. Benefits for retirees under these plans are negotiated as part of the collective bargaining process. For the nine months ended September 30, 2016 and 2015, Health Plans' and Hospitals' employer expense for both current and retiree benefits was $61 million and $57 million, respectively.

(15) Physicians' Retirement Plan

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

At December 31, 2015, the accrued liability for physicians' retirement plan was as follows (in millions):

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

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

The accrued liability for the physicians' retirement plan liability at December 31, 2015 and the change through September 30, 2016 are as follows (in millions):

Accrued physicians' retirement plan liability at December 31, 2015	$	5,901
Provision		450
Benefit payments		(124)
Accrued physicians' retirement plan liability at September 30, 2016		6,227
Less: current portion		(171)
Long-term portion of accrued physicians' retirement plan liability at September 30, 2016	$	6,056

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 nine months ended September 30, physicians' retirement plan provision was as follows (in millions):

	2016	2015
Service cost	$ 238	$ 244
Interest cost	212	195
Amortization of net actuarial loss	42	69
Total benefit expense	492	508
Expected return on assets - investment income included in operating expenses	(320)	(327)
Net benefit expense	172	181
Other changes in projected benefit obligations recognized in net worth		
Amortization of net actuarial loss	(42)	(69)
Total recognized in net worth	(42)	(69)
Total recognized in net periodic benefit cost and net worth	$ 130	$ 112

During 2016, $56 million in estimated net actuarial loss will be amortized from net worth into net benefit expense.

Actuarial assumptions used were as follows:

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

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

2016	$ 171
2017	187
2018	206
2019	226
2020	245
2021 - 2025	1,508

(16) Commitments and Contingencies

(a) Lease and Purchase Commitments

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

At December 31, 2015, minimum commitments under noncancelable leases extending beyond one year were as follows (in millions):

2016	$	314
2017		298
2018		218
2019		151
2020		134
Thereafter		405
Total	$	1,520

Minimum payments above have not been reduced by minimum sublease rentals of $4 million due in the future under noncancelable subleases.

For the nine months ended September 30, 2016 and 2015, total lease expense for all leases was $348 million and $340 million, respectively.

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

At December 31, 2015, minimum purchase commitments, excluding contracts that count towards the $1 billion per annum commitment noted above, extending beyond one year were as follows (in millions):

2016	$	305
2017		280
2018		133
2019		115
2020		60
Thereafter		14
Total	$	907

During the nine months ended September 30, 2016 and 2015, Health Plans' and Hospitals' total purchases under contracts with minimum purchase commitments, excluding those purchases which count towards the $1 billion per annum commitment noted above, were $338 million and $273 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 September 30, 2016 and December 31, 2015, Health Plans and Hospitals had entered into surety instruments and standby letters of credit that totaled $85 million and $81 million, respectively.

Health Plan, Inc. and Hospitals also guarantee payment of workers' compensation liabilities of certain Medical Groups under self-insurance programs. The majority of such liabilities are recorded as other

long-term liabilities of Health Plan, Inc., as payment is provided for under the applicable medical service agreements. In addition to amounts accrued, at both September 30, 2016 and December 31, 2015, pursuant to such guarantees, Health Plan, Inc. and Hospitals are contingently liable for approximately $200 million, respectively, of certain Medical Groups' self-insured workers' compensation liabilities.

(d) Regulatory

Health Plans are 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 September 30, 2016 and December 31, 2015, the regulatory net worth, so defined, exceeded the aggregate regulatory minimum requirements by approximately $27 billion and $23 billion, respectively.

Health Plans' regulated subsidiaries maintain investments in various states where they are licensed. At both September 30, 2016 and December 31, 2015, $5 million 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 our 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.