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

Combined Financial Statements

December 31, 2018 and 2017

(With Independent Auditors' Report Thereon)

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

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

Independent Auditors' Report

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

We have audited the accompanying combined financial statements of Kaiser Foundation Health Plan, Inc. and Subsidiaries and Kaiser Foundation Hospitals and Subsidiaries (Health Plans and Hospitals), which comprise the combined balance sheets as of December 31, 2018 and 2017, and the related combined statements of operations and changes in net worth, and cash flows for the years then ended, and the related notes to the combined financial statements.

Management's Responsibility for the Combined Financial Statements

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

Auditors' Responsibility

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

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

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

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the combined financial position of Health Plans and Hospitals as of December 31, 2018 and 2017, and the results of their operations and their cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated February 14, 2019 on our consideration of Health Plans' and Hospitals' internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing and not to provide an opinion on the effectiveness on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Health Plans' and Hospitals' internal control over financial reporting and compliance.

KPMG LLP

San Francisco, California
February 14, 2019

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

Combined Balance Sheets

December 31, 2018 and 2017

(In millions)

Assets		**2018**		**2017**
Current assets:				
Cash and cash equivalents	$	636	$	552
Current investments		8,035		6,742
Securities lending collateral		996		1,249
Broker receivables		308		388
Due from associated medical groups		19		11
Accounts receivable – net		2,175		2,013
Inventories and other current assets		1,747		1,543
Total current assets		13,916		12,498
Noncurrent investments		32,800		33,819
Land, buildings, equipment, and software – net		26,716		25,907
Goodwill		297		297
Other acquired intangible assets – net		291		293
Other long-term assets		734		569
Total assets	$	74,754	$	73,383
Liabilities and Net Worth				
Current liabilities:				
Accounts payable and accrued expenses	$	4,539	$	4,085
Medical claims payable		2,417		2,303
Due to associated medical groups		1,249		1,212
Payroll and related charges		2,231		2,134
Securities lending payable		996		1,249
Broker payables		538		520
Long-term debt subject to short-term remarketing arrangements – net		475		492
Other current debt		999		769
Other current liabilities		2,665		2,791
Total current liabilities		16,109		15,555
Long-term debt		8,670		8,891
Physicians’ retirement plan liability		7,521		7,966
Pension and other retirement liabilities		7,588		9,378
Other long-term liabilities		2,630		2,640
Total liabilities		42,518		44,430
Net worth		32,236		28,953
Total liabilities and net worth	$	74,754	$	73,383

See accompanying notes to combined financial statements.

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

Combined Statements of Operations and Changes in Net Worth

Years ended December 31, 2018 and 2017

(In millions)

	2018	2017
Revenues:		
Members' dues	$ 54,369	$ 49,204
Medicare	18,267	16,920
Copays, deductibles, fees, and other	7,067	6,617
Total operating revenues	79,703	72,741
Expenses:		
Medical services	38,661	35,784
Hospital services	20,221	18,666
Outpatient pharmacy and optical services	9,063	8,310
Other benefit costs	5,315	4,702
Total medical and hospital services	73,260	67,462
Health Plan administration	4,552	3,563
Total operating expenses	77,812	71,025
Operating income	1,891	1,716
Other income and expense:		
Investment income – net	662	1,932
Interest expense and other income (expense) – net	(50)	150
Total other income and expense	612	2,082
Net income	2,503	3,798
Change in pension and other retirement liability charges	2,675	(3,567)
Change in net unrealized gains on investments	(1,898)	1,628
Other	3	4
Change in net worth	3,283	1,863
Net worth at beginning of year	28,953	27,090
Net worth at end of year	$ 32,236	$ 28,953

See accompanying notes to combined financial statements.

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

Combined Statements of Cash Flows

Years ended December 31, 2018 and 2017

(In millions)

	2018	2017
Cash flows from operating activities:		
Net income	$ 2,503	$ 3,798
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and software amortization	2,566	2,490
Other amortization	(69)	(30)
Loss (gain) recognized on investments – net	306	(1,037)
Loss on land, buildings, equipment, and software – net	27	80
Releases of restricted donations	(32)	—
Changes in assets and liabilities:		
Accounts receivable – net	(122)	233
Due from associated medical groups	(8)	1
Other assets	(383)	(78)
Accounts payable and accrued expenses	423	99
Medical claims payable	114	164
Due to associated medical groups	80	257
Payroll and related charges	97	231
Pension and other retirement liabilities	(212)	(2,529)
Other liabilities	(42)	581
Net cash provided by operating activities	5,248	4,260
Cash flows from investing activities:		
Additions to land, buildings, equipment, and software	(3,357)	(3,272)
Proceeds from sales of land, buildings, and equipment	2	4
Proceeds from investments	31,165	34,894
Investment purchases	(33,505)	(37,246)
Decrease (increase) in securities lending collateral	253	(618)
Broker receivables / payables	98	44
Issuance of notes receivable	(156)	(150)
Prepayment and repayment of notes receivable	171	180
Physicians' retirement plan liability	653	497
Cash paid for acquisition, net of cash assumed	(7)	(1,714)
Other investing	(90)	(67)
Net cash used in investing activities	(4,773)	(7,448)
Cash flows from financing activities:		
Issuance of debt	1,601	6,397
Prepayment and repayment of debt	(1,733)	(3,682)
Increase (decrease) in securities lending payable	(253)	618
Other	(6)	(27)
Net cash provided by (used in) financing activities	(391)	3,306
Net change in cash and cash equivalents	84	118
Cash and cash equivalents at beginning of year	552	434
Cash and cash equivalents at end of year	$ 636	$ 552
Supplemental cash flows disclosure:		
Cash paid for interest – net of capitalized amounts	$ 354	$ 275

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) (collectively referred to herein as Health Plans and Hospitals). Health Plans and Hospitals is primarily comprised of not-for-profit corporations whose capital is available for charitable, educational, research, and related purposes. Health Plans is primarily comprised of health maintenance organizations that are generally exempt from federal and state income taxes. Membership at December 31, 2018 and 2017 was 12.2 million and 11.8 million, respectively. At both December 31, 2018 and 2017, the percentage of enrolled membership in California was approximately 73%. The principal operating subsidiary of Kaiser Foundation Hospitals is Kaiser Hospital Asset Management, Inc. 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 Foundation Health Plan of Washington

Kaiser Health Plan Asset Management, Inc.

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 December 31, 2018 and 2017, the percentage of Health Plans and Hospitals' total labor force covered under collective bargaining agreements was approximately 71%. At December 31, 2018, approximately 30% of the workforce was covered under collective bargaining agreements that were scheduled to expire within one year. At December 31, 2018, less than 1% of the workforce was working under an expired agreement, and less than 1% of the workforce was in a new bargaining unit that was negotiating an agreement.

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

Cost-based methods are used to account for losses incurred under the care and coverage by members and patient types qualifying for treatment as Community Benefit. Assigned members and patients must first prove eligibility based upon family income relative to the Federal Poverty Guidelines. Certain Community Benefit costs are determined using the out-of-pocket costs directly billed to patients or a cost-to-charge ratio applied to uncompensated charges associated with care provided to these patients.

For the year ended December 31, 2018, Community Benefit expenditures (at cost, net of approximately $3.3 billion of related revenues) were $2.8 billion, representing 3.5% of operating revenues. In comparison, for the year ended December 31, 2017, Community Benefit expenditures (at cost, net of approximately $3.2 billion of related revenues) were $2.8 billion, representing 3.9% of operating revenues.

(2) Summary of Significant Accounting Policies

(a) Basis of Presentation

The financial statements of Health Plans and Hospitals are presented on a combined basis due to the operational interdependence of these organizations and because their governing boards and management are substantially the same. These combined financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America (GAAP). All material intercompany balances and transactions have been eliminated. Management has evaluated subsequent events through February 14, 2019, 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 has designated a portion of its 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 these guidelines:

- Substantially all investments are managed by outside investment managers who do not need Health Plans and 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 enters into securities lending agreements whereby certain securities from its portfolios are loaned to other institutions. Securities lent under such agreements remain in the portfolios of Health Plans and Hospitals. Health Plans and Hospitals receives 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 *Summary of Significant Accounting Policies – Fair Value Estimates* note. The fair value of the loaned securities is monitored on a daily basis, with additional collateral obtained or refunded as the fair value of the loaned securities fluctuates.

(e) Broker Receivables and Payables

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

(f) Accounts Receivable – Net

Accounts receivable – net are comprised of members' dues, Medicare receivables, patient receivables, and other receivables. Health Plans and Hospitals provides an allowance for potential uncollectible accounts receivable.

(g) Inventory

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

(h) Land, Buildings, Equipment, and Software

Land, buildings, equipment, and software are stated at cost less accumulated depreciation and amortization. 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. Interest is capitalized on facilities construction and internally developed software work in progress and is added to the cost of the underlying asset.

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 three to seven years. Buildings and equipment are depreciated on a straight-line basis over the estimated useful lives of the various classes of assets, generally ranging from 3 to 40 years.

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

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

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

(i) Goodwill and Other Acquired Intangible Assets

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

Other acquired intangible assets are recognized at fair value on the date of purchase and are amortized on a straight-line basis or accelerated basis over periods from 2 to 16 years. These intangible assets are subject to impairment tests whenever events or circumstances indicate that these assets may be impaired.

(j) Medical Claims Payable

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

(k) Due to Associated Medical Groups

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

(l) Self-Insured Risks

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

(m) Premium Deficiency Reserves

Premium deficiency reserves and the related expense are recognized when it is probable that expected future health care and maintenance costs under a group of existing contracts will exceed anticipated future premiums 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 estimates are periodically updated, and any resulting adjustments are reflected in current operations. At December 31, 2018 and

2017, premium deficiency reserves were $103 million and $0 million, respectively. Given the inherent variability of such estimates, the actual liability could differ significantly from the calculated amount.

(n) Derivative Financial Instruments

Derivative financial instruments are utilized primarily to manage the interest costs and the risk associated with changing interest rates. Health Plans and Hospitals enters 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 enters into derivatives such as put-spread collars with similar investment or commercial banks noted above. The changes in fair value for these derivatives are included in investment income – net.

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

(o) Revenue Recognition

Revenues from contracts with customers include revenues from the following categories: members' dues, Medicare, copays, deductibles, fees, and other revenues. Health Plans and Hospitals recognizes revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which Health Plans and Hospitals expects to be entitled in exchange for those goods or services. At contract inception, Health Plans and Hospitals assesses the promised goods or services in the contract and identifies the performance obligation for each promise to transfer a good or service (or bundle of goods or services) that is distinct. Revenue is recognized when performance obligations are satisfied by transferring control of the good or service provided. For the majority of Health Plans and Hospitals' operations, the primary performance obligation is to provide access to integrated health care services.

The consideration received for goods and services may include variable components. Variable consideration is included in the transaction price to the extent that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the variable consideration is subsequently resolved.

Health Plans satisfies its performance obligation and recognizes revenue ratably over the period in which members are eligible to access integrated health care services.

Members' Dues

Members' dues generally includes amounts received from employer groups, individuals, and government entities. The service promised is access to integrated health care services for a typical term of one year. Members' dues are generally based on a prepaid fee and billed on a monthly, fixed, per member per month basis.

Significant variable consideration items related to members' dues include the following:

- *Copays and Deductibles:* These are member cost share amounts due to Health Plans and Hospitals. Amounts due are based on contractual agreements and evidence of coverage documentation and are typically calculated and collected at the point of service. Amounts may be fixed per unit/service or vary based on venue of care, coverage, and/or whether certain maximum out of pocket or deductible thresholds have been met. Member cost share amounts qualify as variable consideration within the members' dues revenue stream as they would not occur without the existence of a members' dues contract and are not separated from the primary obligation of providing access to integrated health care services.

- *Commercial Risk Adjustment:* Health Plans participates in certain contracts with commercial large groups that include provision for risk adjustment of members' dues based on comparative data provided by Health Plans as well as other health plan vendors participating in these same arrangements. Settlements are typically calculated and paid according to the contract provisions and final settlements are made after the contract terms expire. For the years ended December 31, 2018 and 2017, dues subject to these risk adjustment arrangements comprise 8.1% and 8.2%, respectively, of total members' dues. For the years ended December 31, 2018 and 2017, $99 million and $166 million, respectively, have been recorded as reductions to revenue for these risk adjustment arrangements.

Medicare

Health Plans provides various Medicare products, including the Medicare Advantage Program (Part C) and Medicare cost plans with and without prescription drug coverage and Medicare supplemental products that supplement traditional fee-for-service Medicare coverage. The majority of Health Plans and Hospitals' Medicare revenue is received from Part C. Medicare revenues are based on contracts to provide access to integrated health care services to enrolled Medicare recipients.

Revenues for Part C plans include monthly capitated payments made from the Centers for Medicare & Medicaid Services (CMS), which vary based on health status, demographic status, and other factors.

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

Revenues for Medicare also include a voluntary prescription drug benefit (Part D). Revenues for Part D include monthly capitated payments made from CMS, which are adjusted for health risk factor scores. Revenues for Part D 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.

Medicare Part C and D revenue is subject to governmental audits and potential payment adjustments. CMS performs audits to validate the supporting documentation maintained by Health Plans and its care providers.

Significant variable consideration items related to Medicare include the following:

- *Medicare Part C and D:* adjustments related to annual settlements from CMS, changes in members risk scores, member demographics, and data reconciliations.

In connection with Medicare, members may have to pay copays and/or deductibles.

Third Party Medicaid

Third party Medicaid represents coverage to certain Medicaid enrollees through contracts with third parties known as plan partners and is recorded in copays, deductibles, fees, and other revenues. Health Plans generally receives capitation payments on a monthly, fixed, per member per month basis. Health Plans satisfies its performance obligation and recognizes revenue ratably over the period in which enrollees are eligible to access integrated health care services, which is generally over a one year period.

Significant variable consideration items related to third party Medicaid include the following:

- *Rate Retroactivity*: periodic settlements from plan partners based on rate retroactivity.

For the years ended December 31, 2018 and 2017, revenues related to third party Medicaid contracts were $1.7 billion and $1.5 billion, respectively.

Collectibility Assessment

At contract inception, Health Plans and Hospitals generally collects payments for contracts with customers in advance of the services provided or in the month due, thus a collectibility assessment is typically not required. Health Plans and Hospitals includes an estimate of collectibility as an implicit price concession in the transaction price at contract inception and bases the amount of contractual adjustments on a monthly evaluation of historical collection experience, aged accounts receivable, and current market conditions using a portfolio approach. If actual amounts of consideration ultimately received differ from the estimates, Health Plans and Hospitals adjusts these estimates, which would affect revenues in the period such variances become known.

Disaggregation of Revenue

Health Plans and Hospitals earns substantially all of its revenues from contracts with customers. Revenue and adjustments not related to contracts with customers primarily include amounts for the Affordable Care Act (ACA) Risk Adjustment Program. These amounts are included in other revenue in the table below and in the *Summary of Significant Accounting Policies – The ACA Health Insurance Providers Fee and Risk Adjustment Program* note.

For the year ended December 31, 2018, contracts with customers revenue disaggregated by geographical market were as follows (in millions):

Primary Geographical Markets:		
Northern California	$	31,081
Southern California		27,733
Colorado		4,218
Georgia		2,219
Hawaii		1,679
Mid-Atlantic		4,574
Northwest		4,337
Washington		4,510
Other		524
Total Contracts with Customers Revenue		80,875
Other Revenue		(1,172)
Total Operating Revenue	$	79,703

Contract Asset / Liability Balances

Health Plans and Hospitals generally satisfies its performance obligation when it provides access to integrated health care services in exchange for consideration from its customers. The timing of Health Plans and Hospitals' performance may differ from the timing of the customer's payment, which may result in the recognition of a contract asset or a contract liability. At December 31, 2018, there were no material contract assets with customers. The opening and closing balances of Health Plans and Hospitals' contract liabilities, recorded in other current liabilities were as follows (in millions):

		Contract Liabilities
Opening (January 1, 2018)	$	954
Closing (December 31, 2018)		1,191
Increase	$	237

For the year ended December 31, 2018, the majority of the $954 million contract liability balance at January 1, 2018 was recognized.

Significant Judgments

Below is a summary of significant judgments related to the recognition of revenue that significantly affect the determination of the amount and timing of revenue for Health Plans and Hospitals.

For the performance obligation related to access to integrated health care services, Health Plans and Hospitals transfers promised services by providing access to integrated health care services over time. A time-elapsed output method is used for revenue recognition to measure progress because Health Plans and Hospitals transfers promised services by providing access to integrated health care services over the period that the member is entitled to the services.

Determining a measure of progress requires management to make judgments that affect the timing of revenue recognized. Health Plans and Hospitals has determined that the above method provides a faithful depiction of the transfer of goods or services to the customer. Health Plans and Hospitals stands ready to provide coverage for integrated health care services as needed and efforts are expended evenly throughout the period.

Practical Expedients

Health Plans and Hospitals has elected the following significant practical expedient:

- *Incremental costs of obtaining a contract:* Health Plans and Hospitals has elected to recognize the incremental costs of obtaining a contract (primarily brokerage commissions) as an expense when incurred as the time period of most contracts with customers is one year or less and renewal commission rates are commensurate with new commission rates.

Remaining Performance Obligations

The remaining performance obligations for contracts that are greater than one year were not material for Health Plans and Hospitals.

(p) Pension and Other Postretirement Benefits

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

Health Plans and Hospitals uses a discount rate to determine the present value of the future benefit obligations. The discount rate is established based on a bond portfolio consisting of high quality corporate bonds. From this portfolio, a spot rate curve is interpolated and used to derive a single discount rate.

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.

In March 2017, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2017-07 *Compensation - Retirement Benefits (Topic 715), Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*. The amendments in this update require that an employer disaggregate the service cost component from the other components of net benefit cost and provide explicit guidance on how to present the service cost component and the other components of net benefit cost in the income statement.

Health Plans and Hospitals adopted the provisions of ASU No. 2017-07 as of January 1, 2018 and as a result has changed the method used to report the service and non-service costs of net benefit expense for pension, other postretirement benefits, and the physicians' retirement plan. The impact of this change resulted in the non-service cost components of pension and postretirement benefit costs, previously presented within operating expense, being reported as interest expense and other income (expense) – net. For the year ended December 31, 2018, non-service pension and postretirement benefit costs were $301 million. For the year ended December 31, 2017, $436 million in non-service cost components of pension and postretirement benefit costs, previously presented within operating expense, have been reclassified as interest expense and other income (expense) – net.

(q) Donations and Grants Made or Received

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

(r) Income Taxes

Health Plans and Hospitals are not-for-profit corporations exempt from income taxes under Internal Revenue Code Section 501(a) as organizations described in section 501(c)(3) and the laws of the states in which they operate. Accordingly, Health Plans and Hospitals are generally not subject to federal or state income taxes. Health Plans and Hospitals are subject to income taxes on unrelated business income. A limited number of Health Plans and Hospitals’ subsidiaries are for profit entities and are subject to income taxes. For the years ended December 31, 2018 and 2017, no significant income tax provision has been recorded.

(s) Use of Estimates

The preparation of these combined financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts. Estimated fair value of investments; fair value of assets acquired and liabilities assumed via acquisition; recoverability of goodwill and other acquired intangible assets – net; 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 ACA Risk Adjustment Program 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 combined financial statements as appropriate when agreements are finalized.

(t) Fair Value Estimates

The carrying amounts reported in the combined 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.

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. 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.

Health Plans and Hospitals utilizes 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.

At December 31, 2018 and 2017, Health Plans and Hospitals held derivative financial instruments including interest rate swaps, as well as futures, swaps, and forwards 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.

(u) The ACA Health Insurance Providers Fee and Risk Adjustment Program

The ACA requires Health Plans to pay a Health Insurance Providers (HIP) fee that is assessed based on Health Plans' prior year net premiums as a percentage of total premiums for all U.S. health plans. The Internal Revenue Service (IRS) has provided Health Plans its final assessment of $676 million for 2018, and the amount was paid and expensed in 2018. The HIP fee was suspended for the 2017 calendar year.

The ACA Risk Adjustment Program provides for retrospective adjustment of revenue for non-grandfathered individual and small group market plans, whether inside or outside ACA exchanges. The ACA Risk Adjustment Program is designed such that payments to plans with higher relative risk are funded by transfers from plans with lower relative risk. For the years ended December 31, 2018 and 2017, Health Plans recorded $1.4 billion and $830 million, respectively, in net revenue reductions related to the ACA Risk Adjustment Program. At December 31, 2018 and 2017, net payables for Risk Adjustment settlements were $1.3 billion and $851 million, respectively.

(v) *Natural Classification of Expenses*

Operating expenses classified by function in the combined statements of operations and changes in net worth are presented by their natural classifications for the years ended December 31, as follows (in millions):

	2018					
	Salaries, wages, and benefits	Outside medical costs	Depreciation and software amortization	Pharmacy and supplies costs	Other operating expenses	Total operating expenses
Medical services	$ 4,769	$ 27,597	$ 998	$ 3,116	$ 2,181	$ 38,661
Hospital services	8,897	6,025	1,327	1,750	2,222	20,221
Outpatient pharmacy and optical services	1,933	196	90	6,581	263	9,063
Other benefit costs	742	4,088	20	185	280	5,315
Health Plan administration	1,670	-	131	59	2,692	4,552
Total operating expenses	$ 18,011	$ 37,906	$ 2,566	$ 11,691	$ 7,638	$ 77,812

	2017					
	Salaries, wages, and benefits	Outside medical costs	Depreciation and software amortization	Pharmacy and supplies costs	Other operating expenses	Total operating expenses
Medical services	$ 4,288	$ 25,662	$ 940	$ 2,770	$ 2,124	$ 35,784
Hospital services	8,321	5,255	1,305	1,619	2,166	18,666
Outpatient pharmacy and optical services	1,796	181	84	5,878	371	8,310
Other benefit costs	642	3,729	17	177	137	4,702
Health Plan administration	1,570	-	144	50	1,799	3,563
Total operating expenses	$ 16,617	$ 34,827	$ 2,490	$ 10,494	$ 6,597	$ 71,025

Some categories of natural class expenses are attributable to more than one activity and require allocation, applied on a consistent basis. Outside medical costs include Medical Group costs and other outside medical costs. Property costs including depreciation are allocated on the basis of square footage. Indirect salaries and benefits are allocated on the basis of budgeted full time equivalent employees. Other expenses are assigned directly to specific activities as expenditures are made.

(w) *Liquidity and Availability of Resources*

Cash and cash equivalents, current investments, and accounts receivable – net, as reported on the combined balance sheets at December 31, 2018 and 2017, are the primary liquid resources used by Health Plans and Hospitals to meet general expenditure needs within the next year. As part of liquidity management, Health Plans and Hospitals' policy is to structure and manage its financial assets to be available to meet its general expenditure needs. Health Plans and Hospitals invests cash in excess of daily requirements in current investments. To help manage unanticipated liquidity needs, Hospitals has both a credit facility and commercial paper program, as described in the *Debt* note. Additionally, although intended to satisfy long-term obligations, 81% of noncurrent investments at December 31, 2018, could be utilized within the next year if necessary.

(x) Recently Issued Accounting Standards

In May 2014, the FASB issued ASU No. 2014-09 *Revenue from Contracts with Customers (Topic 606)*. The ASU replaces most existing revenue recognition guidance in GAAP. Topic 606 was adopted January 1, 2018. The standard permits the use of either the retrospective or cumulative effect transition method. Management selected the cumulative effect transition method. Management has applied the standard to contracts that are not completed at the date of adoption. The adoption of Topic 606 did not have a significant impact on the results of operations. There would not have been a material impact to any financial statement line item in the current period as compared with the guidance that was in effect prior to the change. Disclosures in the *Summary of Significant Accounting Policies – Revenue Recognition* note have been updated as required by the standard.

In January 2016, the FASB issued ASU No. 2016-01 *Financial Instruments – Overall (Subtopic 825-10)*. The standard requires entities to measure equity investments that are not accounted for under the equity method or do not result in consolidation to be recorded at fair value and recognize any changes in fair value to net income. Investments that qualify for a practicability exception would not require a change in accounting. The disclosure of fair value of investments held at amortized cost will no longer be required. The new standard is effective for Health Plans and Hospitals on January 1, 2019. 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. Management expects to record a cumulative effect adjustment upon adoption of approximately $1.3 billion as of January 1, 2019.

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. Topic 842 requires a lessee to record a right-of-use asset and a lease liability for almost all leases. These leases will be classified as either operating or finance, with classification affecting the pattern of expense recognition. The new standard is effective for Health Plans and Hospitals on January 1, 2019. In July 2018, the FASB issued an update to its guidance providing companies with the option to adopt the provisions of the standard prospectively without adjusting comparative periods; Health Plans and Hospitals is electing this option.

Health Plans and Hospitals is electing certain relief options offered in Topic 842 including the package of transition practical expedients, the option not to separate lease and non-lease components for certain classes of assets, and the option not to recognize right-of-use assets and lease liabilities that arise from short-term leases (i.e. leases with terms of twelve months or less). Health Plans and Hospitals is not electing the hindsight practical expedient, which allows entities to use hindsight when determining lease term and impairment of right-of-use assets.

Management expects to record approximately $1.4 billion and $1.6 billion for right-of-use assets and lease liabilities, respectively, on its combined balance sheet from a lessee perspective as of January 1, 2019. The adoption of Topic 842 is not expected to have a significant impact on the results of operations or cash flows. Health Plans and Hospitals does not have significant lessor activity. Management will include new disclosures in 2019 in accordance with Topic 842.

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 of the identified issues about the financial reporting for not-for-profits. The new standard was adopted by Health Plans and Hospitals for the annual period beginning on January 1, 2018. The standard requires the use of the retrospective transition method. Disclosures in the *Summary of Significant Accounting Policies – Natural Classification of Expenses* note and the *Summary of Significant Accounting Policies – Liquidity and Availability of Resources* note have been added as required by the standard for the classification of expenses and management of liquid resources, respectively.

In January 2017, the FASB issued ASU No. 2017-04 *Intangibles – Goodwill and Other (Topic 350)*, *Simplifying the Test for Goodwill Impairment*. The amendments in this update eliminate Step 2 from the goodwill impairment test in an effort to simplify the subsequent measurement of goodwill. Step 2 requires determining the fair value at the impairment testing date of assets and liabilities (including unrecognized assets and liabilities) following the procedure that would be required in determining the fair value of assets acquired and liabilities assumed in a business combination. The new standard is effective for Health Plans and Hospitals on January 1, 2022. The impact of adoption will result in goodwill impairment being measured based on comparison with the fair value of the reporting unit.

In June 2018, the FASB issued ASU No. 2018-08 *Not-For-Profit Entities (Topic 958): Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made.* The amendments in this update clarify and improve current guidance about whether a transfer of assets is a contribution or an exchange transaction. Additional guidance about when a contribution should be recognized is also included in the amendments. These amendments apply to both resources received by a recipient and given by a resource provider. The new standard is effective for Health Plans and Hospitals on January 1, 2019. The adoption of ASU No. 2018-08 is not expected to have a significant impact on the combined financial statements and related disclosures.

In August 2018, the FASB issued ASU No. 2018-14 *Compensation – Retirement Benefits – Defined Benefit Plans – General (Subtopic 715-20): Disclosure Framework – Changes to the Disclosure Requirements for Defined Benefit Plans*. The amendments in this update remove disclosures that no longer are considered cost beneficial, clarify the specific requirements of disclosures, and add disclosure requirements identified as relevant including an explanation of the reasons for significant gains and losses related to changes in the benefit obligation. The new standard is effective for Health Plans and Hospitals on January 1, 2021. Early application is permitted. The standard requires the amendments to be applied on a retrospective basis. Upon adoption, management will update disclosures as required by the standard.

(y) Reclassifications

Certain reclassifications have been made in these combined financial statements to conform 2017 information to the 2018 presentation.

(3) Acquisition of Group Health Cooperative

On February 1, 2017, KFHPW Holdings (Holdings), a subsidiary of Health Plan, Inc., acquired and became the sole corporate member of Group Health Cooperative (GHC), a Washington nonprofit corporation (the "Acquisition"). After closing of the Acquisition, GHC remained the sole shareholder of Group Health Options, Inc. (GHO), a Washington for-profit corporation. Following the Acquisition, GHC was renamed "Kaiser Foundation Health Plan of Washington", and GHO was renamed "Kaiser Foundation Health Plan of Washington Options, Inc." (Kaiser Foundation Health Plan of Washington and its subsidiaries are collectively referred to herein as Washington Health Plans).

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

At closing, Holdings transferred approximately $1.8 billion in cash, of which $75 million was deposited into escrow for possible future indemnity claims. Indemnity claims of $5.4 million have been collected. Remaining funds have been released from escrow. In addition to and separate from this transaction consideration, the Acquisition Agreement requires $1 billion to be spent over the 10 year period following closing (subject to standard capital and budget approval processes) for capital improvements and key investments in infrastructure and other improvements at Washington Health Plans, and also states that $800 million in community benefit contributions is expected to be made over the same period. During the years ended December 31, 2018 and 2017, $145 million and $215 million, respectively, in capital and other investments were made. At December 31, 2018, $640 million of remaining capital and other investment commitments are required to be made relating to the Acquisition.

Prior to the Acquisition, Group Health Permanente, P.C. (GHP), which is an independent medical group, provided physician and certain other medical services exclusively to Washington Health Plans' members. GHP continues to be an independent medical group, not controlled by Health Plans or Hospitals or any of its subsidiaries; therefore, their financial statements are not combined or consolidated by Health Plans or Hospitals. As part of the successful completion of the Acquisition, Holdings and GHP entered into agreements to continue that arrangement following closing of the Acquisition, including payments to GHP of up to $200 million, recognized primarily as operating expenses and intangible assets. Payments of $19 million and $140 million have been made to GHP in 2018 and 2017, respectively. Additional payments may be made based on achieved milestones. Following the Acquisition, GHP was renamed "Washington Permanente Medical Group, P.C.".

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

Current investments	$	274
Accounts receivable		199
Other current assets		179
Noncurrent investments		777
Land, buildings, equipment, and software		794
Goodwill		297
Other acquired intangible assets		251
Other long-term assets		26
Medical claims payable		(277)
Other current liabilities		(451)
Pension and other retirement liabilities		(110)
Other long-term liabilities		(159)
Total purchase price	$	1,800

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

(4) Investments

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

At December 31, 2018, 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	$ 21	$ —	$ —	$ 21
Foreign equity securities	3	—	—	3
Debt securities issued by the U.S. government	—	2,486	—	2,486
Debt securities issued by U.S. government agencies and corporations	—	17	—	17
Debt securities issued by U.S. states and political subdivisions of states	—	53	—	53
Foreign government debt securities	—	83	—	83
U.S. corporate debt securities	—	2,579	—	2,579
Foreign corporate debt securities	—	984	—	984
U.S. agency mortgage-backed securities	—	407	—	407
Non-U.S. agency mortgage-backed securities	—	256	—	256
Other asset-backed securities	—	993	—	993
Short-term investment funds	—	151	—	151
Other	—	2	—	2
Total	$ 24	$ 8,011	$ —	$ 8,035

At December 31, 2018, 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	$ 5,280	$ 776	$ —	$ 6,056
Foreign equity securities	2,624	1,130	—	3,754
Global equity funds	—	521	—	521
Debt securities issued by the U.S. government	—	1,970	—	1,970
Debt securities issued by U.S. government agencies and corporations	—	56	—	56
Debt securities issued by U.S. states and political subdivisions of states	—	196	—	196
Foreign government debt securities	—	1,493	—	1,493
U.S. corporate debt securities	—	5,164	—	5,164
Foreign corporate debt securities	—	1,922	—	1,922
U.S. agency mortgage-backed securities	—	865	—	865
Non-U.S. agency mortgage-backed securities	—	212	2	214
Other asset-backed securities	—	342	—	342
Short-term investment funds	—	792	—	792
Other	21	685	1	707
	$ 7,925	$ 16,124	$ 3	24,052
Alternative investments:				
Absolute return				2,092
Private equity				5,825
Risk parity				831
Total				$ 32,800

At December 31, 2017, the estimated fair value of current investments by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
U.S. equity securities	$ 22	$ —	$ —	$ 22
Debt securities issued by the U.S. government	—	1,691	—	1,691
Debt securities issued by U.S. government agencies and corporations	—	30	—	30
Debt securities issued by U.S. states and political subdivisions of states	—	79	—	79
Foreign government debt securities	—	83	—	83
U.S. corporate debt securities	—	2,336	—	2,336
Foreign corporate debt securities	—	909	—	909
U.S. agency mortgage-backed securities	—	492	—	492
Non-U.S. agency mortgage-backed securities	—	210	—	210
Other asset-backed securities	—	648	—	648
Short-term investment funds	—	242	—	242
Total	$ 22	$ 6,720	$ —	$ 6,742

At December 31, 2017, the estimated fair value of noncurrent investments by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Significant unobservable inputs level 3	Total
U.S. equity securities	$ 6,155	$ 1,312	$ —	$ 7,467
Foreign equity securities	2,603	2,198	—	4,801
Global equity funds	—	541	—	541
Debt securities issued by the U.S. government	—	1,747	—	1,747
Debt securities issued by U.S. government agencies and corporations	—	65	—	65
Debt securities issued by U.S. states and political subdivisions of states	—	214	—	214
Foreign government debt securities	—	1,735	—	1,735
U.S. corporate debt securities	—	4,934	—	4,934
Foreign corporate debt securities	—	1,830	—	1,830
U.S. agency mortgage-backed securities	—	698	—	698
Non-U.S. agency mortgage-backed securities	—	270	2	272
Other asset-backed securities	—	312	—	312
Short-term investment funds	—	710	—	710
Other	132	633	1	766
	$ 8,890	$ 17,199	$ 3	26,092
Alternative investments:				
Absolute return				2,164
Private equity				4,806
Risk parity				757
Total				$ 33,819

At December 31, 2018, 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	$ 5,232	$ 845	$ —	$ 6,077
Foreign equity securities	3,376	381	—	3,757
Global equity funds	452	69	—	521
Debt securities issued by the U.S. government	4,394	62	—	4,456
Debt securities issued by U.S. government agencies and corporations	70	3	—	73
Debt securities issued by U.S. states and political subdivisions of states	226	23	—	249
Foreign government debt securities	1,545	31	—	1,576
U.S. corporate debt securities	7,660	83	—	7,743
Foreign corporate debt securities	2,882	24	—	2,906
U.S. agency mortgage-backed securities	1,255	17	—	1,272
Non-U.S. agency mortgage-backed securities	462	8	—	470
Other asset-backed securities	1,324	11	—	1,335
Short-term investment funds	943	—	—	943
Other	706	3	—	709
Total	$ 30,527	$ 1,560	$ —	$ 32,087

At December 31, 2017, debt and equity securities available-for-sale were as follows (in millions):

	Amortized cost	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. equity securities	$ 6,135	$ 1,354	$ —	$ 7,489
Foreign equity securities	3,571	1,230	—	4,801
Global equity funds	379	162	—	541
Debt securities issued by the U.S. government	3,413	25	—	3,438
Debt securities issued by U.S. government agencies and corporations	91	4	—	95
Debt securities issued by U.S. states and political subdivisions of states	253	40	—	293
Foreign government debt securities	1,690	128	—	1,818
U.S. corporate debt securities	6,958	312	—	7,270
Foreign corporate debt securities	2,606	133	—	2,739
U.S. agency mortgage-backed securities	1,180	10	—	1,190
Non-U.S. agency mortgage-backed securities	472	10	—	482
Other asset-backed securities	947	13	—	960
Short-term investment funds	952	—	—	952
Other	729	37	—	766
Total	$ 29,376	$ 3,458	$ —	$ 32,834

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

	At December 31, 2018		At December 31, 2017	
	Amortized cost	Fair value	Amortized cost	Fair value
Due in one year or less	$ 1,889	$ 1,890	$ 2,197	$ 2,208
Due after one year through five years	7,612	7,675	5,776	5,870
Due after five years through ten years	4,336	4,376	4,342	4,483
Due after ten years	4,589	4,714	4,377	4,810
U.S. agency mortgage-backed securities	1,255	1,272	1,180	1,190
Non-U.S. agency mortgage-backed securities	462	470	472	482
Other asset-backed securities	1,324	1,335	947	960
Total	$ 21,467	$ 21,732	$ 19,291	$ 20,003

For the year ended December 31, 2018, the reconciliation of investments with fair value measurements using significant unobservable inputs (level 3) was as follows (in millions):

	Debt securities
Beginning balance	$ 3
Transfers into level 3	—
Total net losses:	
Realized	—
Unrealized	—
Purchases	—
Sales	—
Settlements	—
Ending balance	$ 3
Total realized and unrealized year-to-date net gains (losses) related to assets held at December 31, 2018	$ —

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

	Equity securities	Debt securities	Total
Beginning balance	$ —	$ 9	$ 9
Transfers into level 3	5	—	5
Total net losses:			
Realized	—	—	—
Unrealized	(1)	(1)	(2)
Purchases	—	—	—
Sales	(4)	—	(4)
Settlements	—	(5)	(5)
Ending balance	$ —	$ 3	$ 3
Total realized and unrealized year-to-date net gains (losses) related to assets held at December 31, 2017	$ —	$ —	$ —

Transfers between fair value input levels, if any, are recorded at the end of the reporting period. Transfers between fair value input levels occur when valuation inputs used to record or disclose assets or liabilities change from one level of the valuation hierarchy to another. During the years ended December 31, 2018 and 2017, there were no transfers between assets with inputs with quoted prices in active markets for identical assets (level 1) and assets with inputs with significant other observable inputs (level 2).

Investments include specific funds held in trust accounts related to collateral requirements for certain reinsurance agreements. At December 31, 2018 and 2017, the values of these funds were $39 million and $34 million, respectively.

Absolute return investments use advanced investment strategies, including derivatives, to generate positive long-term risk adjusted returns. Private equity investments consist of funds that make direct investments in private companies. Risk parity funds use risk as the primary factor to allocate investments among asset classes. Management meets with alternative investment fund managers periodically to assess portfolio performance and reporting and exercises oversight over fund managers. At December 31, 2018, Hospitals had original commitments related to alternative investments of $11.2 billion, of which $6.7 billion was invested, leaving $4.5 billion of remaining commitments. At December 31, 2017, Hospitals had original commitments related to alternative investments of $9.1 billion, of which $5.6 billion was invested, leaving $3.5 billion of remaining commitments.

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

	2018	2017
Other-than-temporary impairment	$ (1,599)	$ (387)
Recognized gains	1,184	1,161
Recognized losses	(244)	(148)
Income (loss) from equity method alternative investments	796	852
Interest, dividends, and other income – net	1,061	964
Derivative income	34	(42)
Total investment income (loss) – net	1,232	2,400
Less investment income included in interest expense and other income (expense) – net	(570)	(468)
Investment income – net	$ 662	$ 1,932

For the years ended December 31, 2018 and 2017, Health Plans and Hospitals recorded impairment of certain investments in accordance with the policy described in the *Summary of Significant Accounting Policies – Investments* note. During the years ended December 31, 2018 and 2017, there was $18 million and $5 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. At December 31, 2018, absolute return and risk parity investments of $649 million were subject to lock-up periods of up to 2 years. Private equity agreements do not include provisions for redemption. Distributions will be received as the underlying investments of the funds are liquidated, which is expected over the next 11 years.

The majority of debt and equity securities can be redeemed within 10 days. At December 31, 2018, debt and equity investment funds of $1.6 billion were redeemable between 10 and 30 days. At December 31, 2018, equity investment funds of $797 million had a redemption period of between 30 days and one year. No debt or equity investments require a redemption period of greater than one year.

(5) Derivative Instruments

(a) Interest Rate Swaps

At December 31, 2018 and 2017, Health Plans and Hospitals had 11 agreements to manage interest rate fluctuations (Interest Rate Swaps) with a total notional amount of $1.1 billion and $1.2 billion, respectively. At December 31, 2018 and 2017, the fair values of these agreements were $(192) million and $(229) million, respectively, and were recorded in other long-term liabilities. For the years ended December 31, 2018 and 2017, Health Plans and Hospitals recorded $21 million and $28 million, respectively, in interest expense relating to the Interest Rate Swaps. For the years ended December 31, 2018 and 2017, net changes in fair values totaled $37 million and $22 million, respectively, and were recorded in investment income – net.

These derivatives contain reciprocal provisions whereby if Health Plans and Hospitals' or the counterparties' credit rating was to decline to certain levels, provisions would be triggered requiring Health Plans and Hospitals or the counterparties to provide certain collateral. At December 31, 2018 and 2017, no collateral was required to be posted by either Health Plans and Hospitals or the counterparties.

(b) Derivatives Held in Investment Portfolios

At December 31, 2018 and 2017, Health Plans and Hospitals' portfolio managers held \$(19) million and \$1 million, respectively, of futures, forwards, options, and swaps to attempt to protect certain investments against volatility. For the years ended December 31, 2018 and 2017, net changes in fair values totaled \$30 million and \$(72) million, respectively, and were recorded in investment income – net. For the years ended December 31, 2018 and 2017, gains (losses) resulting from derivative settlements totaled \$(33) million and \$8 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 *Summary of Significant Accounting Policies – Fair Value Estimates* note.

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

(In millions)

Derivatives not designated as hedging instruments	Statement of operations category	Gain (loss) recognized in income on derivatives for the years ended December 31, 2018	2017
Interest rate swaps – related to debt	Investment income – net	$ 37	$ 22
Interest rate swaps – other	Investment income – net	(6)	(22)
Futures and forwards	Investment income – net	40	(49)
Options, rights, and warrants	Investment income – net	(4)	(1)
		$ 67	$ (50)

Information on Derivative Settlement Costs Recognized in Income

(In millions)

Derivatives not designated as hedging instruments	Statement of operations category	Gain (loss) recognized in income on derivatives for the years ended December 31, 2018	2017
Interest rate swaps – related to debt	Interest expense	$ (21)	$ (28)
Interest rate swaps – other	Investment income – net	18	11
Futures and forwards	Investment income – net	(58)	(10)
Options, rights, and warrants	Investment income – net	7	7
		$ (54)	$ (20)

Information on Fair Value of Derivative Instruments – Assets

(In millions)

Derivatives not designated as hedging instruments	Balance sheet category	Fair value at December 31, 2018	2017
Interest rate swaps – other	Noncurrent investments	$ 56	$ 36
Futures and forwards	Noncurrent investments	25	51
Options, rights, and warrants	Noncurrent investments	11	13
		$ 92	$ 100

Information on Fair Value of Derivative Instruments – Liabilities

(In millions)

Derivatives not designated as hedging instruments	Balance sheet category	Fair value at December 31, 2018	2017
Interest rate swaps – related to debt	Other long-term liabilities	$ 192	$ 229
Interest rate swaps – other	Other long-term liabilities	62	36
Futures and forwards	Other long-term liabilities	35	52
Options, rights, and warrants	Other long-term liabilities	14	11
		$ 303	$ 328

(6) Accounts Receivable – Net

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

		2018		2017
Members' dues	$	842	$	889
Patient services		457		600
Medicare		296		196
Risk Adjustment receivables		4		9
Other		582		573
		2,181		2,267
Allowances for bad debt		(6)		(254)
Total	$	2,175	$	2,013

(7) Inventories and Other Current Assets

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

		2018		2017
Inventories – net	$	854	$	840
Prepaid expenses		803		577
Other		90		126
Total	$	1,747	$	1,543

(8) Land, Buildings, Equipment, and Software – Net

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

	2018	2017
Land	$ 2,195	$ 2,070
Buildings and improvements	35,989	34,835
Furniture, equipment, and software	12,855	12,324
Construction and software development in progress	2,336	1,716
	53,375	50,945
Accumulated depreciation and amortization	(26,659)	(25,038)
Total	$ 26,716	$ 25,907

Health Plans and Hospitals capitalizes interest costs on borrowings incurred during the construction, upgrade, or development of qualifying assets. Capitalized interest is added to the cost of the underlying assets and is depreciated or amortized over the useful lives of the assets. During the years ended December 31, 2018 and 2017, Health Plans and Hospitals capitalized $38 million and $22 million, respectively, of interest in connection with various capital projects.

Asset retirement obligations relate primarily to the following: leased building restoration, building demolition, building materials containing asbestos, leaded wall shielding, storage tanks (above ground and below ground), chillers or cooling tower chemicals, mercury in large fixed-components, polychlorinated biphenyl window caulk, and hard drives requiring data wiping prior to disposal. At December 31, 2018 and 2017, the liability for asset retirement obligations was $103 million and $121 million, respectively. At December 31, 2018 and 2017, the unamortized asset related to these retirement obligations was $35 million and $42 million, respectively.

(9) Goodwill and Other Acquired Intangible Assets – Net

The carrying amount of goodwill for the years ended December 31, 2018 and 2017 were as follows (in millions):

	2018	2017
Balance as of January 1	$ 297	$ —
Goodwill acquired during the year	—	297
Balance as of December 31	$ 297	$ 297

There was no goodwill impairment loss in 2018 or 2017.

At December 31, 2018, other acquired intangible assets – net were as follows (in millions):

	Gross carrying amount	Accumulated amortization	Net carrying amount
Amortizing intangible assets:			
Member relationships	$ 133	$ (53)	$ 80
Intellectual property	78	(10)	68
Other	173	(30)	143
Total	$ 384	$ (93)	$ 291

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

	Weighted average amortization period	Gross carrying amount	Accumulated amortization	Net carrying amount
Amortizing intangible assets:				
GHC acquired intangible assets:				
Member relationships	9 years	$ 133	$ (25)	$ 108
Intellectual property	15 years	39	(2)	37
Other	11 years	79	(9)	70
Total GHC acquired intangible assets	11 years	251	(36)	215
Intellectual property	15 years	39	(2)	37
Other	13 years	44	(3)	41
Total other acquired intangible assets	14 years	83	(5)	78
Total	11 years	$ 334	$ (41)	$ 293

Intangible assets subject to amortization are amortized on a straight-line or accelerated basis over their useful lives. For the years ended December 31, 2018 and 2017, aggregate amortization expense related to amortizing intangible assets was $52 million and $41 million, respectively.

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

2019	$ 45
2020	40
2021	33
2022	29
2023	25

(10) Medical Claims Payable

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

	2018	2017
Balances at January 1	$ 2,303	$ 1,862
Acquired business at February 1, 2017	—	277
Incurred related to:		
Current year	13,326	11,816
Prior years	(114)	(95)
Total incurred	13,212	11,721
Paid related to:		
Current year	11,180	9,740
Prior years	1,918	1,817
Total paid	13,098	11,557
Balance at December 31	$ 2,417	$ 2,303

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

(11) Other Liabilities

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

	2018	2017
Self-insured risks	$ 403	$ 378
Dues collected in advance	904	768
Physicians' retirement plan liability	219	199
Other	1,139	1,446
Total	$ 2,665	$ 2,791

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

	2018	2017
Self-insured risks	$ 1,629	$ 1,632
Derivatives liability	303	328
Due to associated medical groups	243	199
Other	455	481
Total	$ 2,630	$ 2,640

(12) Debt

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

	2018	2017
Tax-exempt revenue bonds and taxable bonds and notes:		
1.30% to 1.85% variable rate due through 2049	$ 3,643	$ 3,660
3.15% to 5.00% fixed rate due through 2051	6,461	6,473
Others at various rates due through 2031	40	19
Total	$ 10,144	$ 10,152
Other current debt:		
Commercial paper	$ 750	$ 750
Current portion of long-term debt	249	19
Long-term debt subject to short-term remarketing arrangements – net	475	492
Long-term debt classified as a long-term liability	8,670	8,891
Total	$ 10,144	$ 10,152

In May 2017, Hospitals issued $2.1 billion of taxable bonds and $2.1 billion of tax-exempt revenue bonds. Total proceeds from issuance, which included $200 million of bond premium, were $4.4 billion. Additionally, in May 2017, $1.4 billion of bond proceeds were used to refinance taxable commercial paper.

The fair value of long-term debt is based on level 2 inputs for debt with similar risk, terms, and remaining maturities. At both December 31, 2018 and 2017, the carrying amount of long-term debt totaled $9.4 billion. At December 31, 2018 and 2017, the estimated fair value of long-term debt was approximately $9.6 billion and $9.9 billion, respectively.

At both December 31, 2018 and 2017, repurchase of variable rate bonds totaling $2.9 billion may be required at earlier than stated maturity. These bonds may be remarketed rather than repurchased. Health Plans and Hospitals has provided self liquidity for the variable rate demand bonds with put options. Additionally, at both December 31, 2018 and 2017, management had the ability to finance the acquisition of up to $2.4 billion of any unremarketed bonds that are put, using available long-term credit facilities. At December 31, 2018 and 2017, $475 million and $492 million, respectively, of these variable rate demand bonds were classified in current liabilities.

At December 31, 2018 and 2017, $200 million and $215 million, respectively, of the above tax-exempt fixed-rate revenue bonds and taxable fixed-rate bonds represented a net unamortized premium balance. At December 31, 2018 and 2017, $(39) million and $(42) 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):

2019	$	999
2020		20
2021		22
2022		802
2023		22
Thereafter		8,118
Total	$	9,983

Credit Facility

Hospitals' credit facility of $2.4 billion terminates in September 2022. Various interest rate options are available under this facility. Any revolving borrowings mature on the termination date. Hospitals pays facility fees, which range from 0.05% to 0.15% per annum, depending upon Hospitals' long-term senior unsecured debt rating. At December 31, 2018, the facility fee was at an annual rate of 0.05%. At December 31, 2018 and 2017, no amounts were outstanding under this credit facility.

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

Taxable Commercial Paper Program

Hospitals maintains a commercial paper program providing for the issuance of up to $2.4 billion in aggregate maturity value of short-term indebtedness. The commercial paper is issued in denominations of $100,000 and will bear such interest rates, if interest-bearing, or will be sold at such discount from their face amounts, as agreed upon by Hospitals and the dealer acting in connection with the commercial paper program. The commercial paper may be issued with varying maturities up to a maximum of 270 days from the date of issuance. At both December 31, 2018 and 2017, commercial paper of $750 million, was outstanding under this program and is included within other current debt.

(13) Pension Plans

(a) Defined Benefit Plan

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

For financial reporting purposes, the projected unit credit method is used. At December 31, 2018 and 2017, substantially all pension fund assets were held in a group trust. At December 31, 2018 and 2017, trust assets were invested primarily in fixed-income and equity securities, with approximately 25% and 21%, respectively, of trust assets, net of liabilities, invested in alternative investments.

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

	2018	2017
Change in projected benefit obligation (PBO):		
Benefit obligation at beginning of year	$ 23,632	$ 18,578
Pension benefit obligation acquired through acquisition	—	844
Service cost	1,484	1,167
Interest cost	809	724
Net actuarial loss (gain)	(2,830)	3,782
Benefits paid	(750)	(1,463)
Benefit obligation at end of year	$ 22,345	$ 23,632
Accumulated benefit obligation at end of year	$ 17,069	$ 17,925
Change in Health Plans and Hospitals' share of trust assets:		
Fair value of plan assets at beginning of year	$ 15,693	$ 11,771
Fair value of plan assets acquired through acquisition	—	770
Actual return on plan assets	(753)	2,214
Contributions	1,593	2,401
Benefits paid	(750)	(1,463)
Fair value of plan assets at end of year	$ 15,783	$ 15,693
Funded status	$ (6,562)	$ (7,939)
Amounts recognized in the balance sheet consist of:		
Noncurrent assets	$ —	$ —
Current liabilities	—	—
Pension and other retirement liabilities	(6,562)	(7,939)
	$ (6,562)	$ (7,939)
Amounts recognized in net worth:		
Net actuarial loss	$ 6,341	$ 7,882
Prior service cost	76	87
	$ 6,417	$ 7,969

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

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

	2018	2017
Service cost	$ 1,484	$ 1,167
Interest cost	809	724
Expected return on plan assets	(1,079)	(989)
Amortization of net actuarial loss	542	277
Amortization of prior service cost	11	12
Net pension expense	1,767	1,191
Other changes in plan assets and PBO recognized in net worth:		
Net actuarial loss (gain)	(999)	2,557
Prior service cost	—	—
Amortization of net actuarial loss	(542)	(277)
Amortization of prior service cost	(11)	(12)
Total recognized in net worth	(1,552)	2,268
Total recognized in net periodic benefit cost and net worth	$ 215	$ 3,459

During 2019, $200 million and $10 million in estimated net actuarial loss and prior service cost, respectively, will be amortized from net worth into net pension expense.

Actuarial assumptions used were as follows:

	2018	2017
Discount rates at January 1 for calculating pension expense	3.80%	4.15% - 4.45%
Discount rate for calculating December 31 PBO	4.50%	3.60% - 3.80%
Discount rates for calculating February 1 PBO	N/A	4.15% - 4.35%
Salary scale for calculating pension expense	4.20%	3.00% - 4.50%
Salary scale for calculating December 31 PBO	4.20%	3.50% - 4.50%
Salary scale for calculating February 1 PBO	N/A	3.50% - 4.50%
Expected long-term rates of return on plan assets for calculating pension expense	7.00%	5.25% - 7.00%

During 2019, management expects to contribute approximately $1.1 billion to the Plan.

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

2019	$	916
2020		1,012
2021		1,100
2022		1,184
2023		1,270
2024–2028		7,560

Explanation of Investment Strategies and Policies

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

Capital Market Assumption Methodology

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

At December 31, 2018, the estimated fair value of total pension trust assets – net by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Total
Assets:			
Cash and cash equivalents	$ 148	$ 992	$ 1,140
Broker receivables	—	320	320
Securities lending collateral	—	949	949
U.S. equity securities	6,311	603	6,914
Foreign equity securities	5,347	2,152	7,499
Global equity funds	—	340	340
Debt securities issued by the U.S. government	—	1,770	1,770
Debt securities issued by U.S. government agencies and corporations	—	46	46
Debt securities issued by U.S. states and political subdivisions of states	—	220	220
Foreign government debt securities	—	600	600
U.S. corporate debt securities	—	4,646	4,646
Non-U.S. corporate debt securities	—	1,259	1,259
U.S. agency mortgage-backed securities	—	156	156
Non-U.S. agency mortgage-backed securities	—	51	51
Other	—	943	943
Total assets	11,806	15,047	26,853
Liabilities:			
Broker payables	—	639	639
Securities lending payable	—	949	949
Other liabilities	14	294	308
Total liabilities	14	1,882	1,896
Fair value of pension trust assets – net	$ 11,792	$ 13,165	24,957
Investments measured at net asset value (NAV):			
Alternative investments:			
Absolute return			1,712
Private equity			5,272
Risk parity			1,248
Total pension trust assets – net			$ 33,189

At December 31, 2018, Health Plans and Hospitals' share of pension trust assets was 47.6%, or $15.8 billion. The remaining share of pension trust assets is for Medical Groups and a related party associated with Medical Groups.

At December 31, 2017, the estimated fair value of total pension trust assets – net by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Total
Assets:			
Cash and cash equivalents	$ 686	$ 1,083	$ 1,769
Broker receivables	—	331	331
Securities lending collateral	—	1,181	1,181
U.S. equity securities	6,371	494	6,865
Foreign equity securities	6,144	2,657	8,801
Global equity funds	—	276	276
Debt securities issued by the U.S. government	—	1,463	1,463
Debt securities issued by U.S. government agencies and corporations	—	53	53
Debt securities issued by U.S. states and political subdivisions of states	—	214	214
Foreign government debt securities	—	614	614
U.S. corporate debt securities	—	4,675	4,675
Non-U.S. corporate debt securities	—	1,295	1,295
U.S. agency mortgage-backed securities	—	82	82
Non-U.S. agency mortgage-backed securities	—	47	47
Other	1	720	721
Total assets	13,202	15,185	28,387
Liabilities:			
Broker payables	—	609	609
Securities lending payable	—	1,181	1,181
Other liabilities	12	296	308
Total liabilities	12	2,086	2,098
Fair value of pension trust assets – net	$ 13,190	$ 13,099	26,289
Investments measured at NAV:			
Alternative investments:			
Absolute return			1,770
Private equity			4,150
Risk parity			1,090
Total pension trust assets – net			$ 33,299

At December 31, 2017, Health Plans and Hospitals' share of pension trust assets was 47.1%, or $15.7 billion. The remaining share of pension trust assets is for Medical Groups and a related party associated with Medical Groups.

During the years ended December 31, 2018 and 2017, 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 for calculating pension expense were as follows:

	2018 and 2017 target
Equity securities	45%
Debt securities	30%
Alternative investments	25%
Total	100%

Alternative investments, which include absolute return, risk parity, and private equity, held in the pension trust are reported at NAV as a practical expedient for fair value. Absolute return investments use advanced investment strategies, including derivatives, to generate positive long-term risk adjusted returns. Private equity investments consist of funds that make direct investments in private companies. Risk parity funds use risk as the primary factor to allocate investments among asset classes. At December 31, 2018, the trust had original commitments related to alternative investments of $10.1 billion, of which $5.6 billion was invested, leaving $4.5 billion of remaining commitments. At December 31, 2017, the trust had original commitments related to alternative investments of $8.0 billion, of which $4.5 billion was invested, leaving $3.5 billion of remaining commitments.

Absolute return, risk parity, and private equity investments include redemption restrictions. Absolute return and risk parity investments require 10 to 90 day written notice of intent to withdraw and are often subject to the approval and capital requirements of the fund manager. At December 31, 2018, absolute return and risk parity investments of $574 million were subject to lock-up periods of up to 2 years. Private equity agreements do not include provisions for redemption. Distributions will be received as the underlying investments of the funds are liquidated, which is expected over the next 11 years.

The majority of debt and equity securities can be redeemed within 10 days. At December 31, 2018, debt and equity investment funds of $2.2 billion were redeemable between 10 and 30 days. Debt and equity investment funds of $187 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 has defined contribution plans for eligible employees. Employer contributions and costs are typically based on a percentage of covered employees' eligible compensation. During the years ended December 31, 2018 and 2017, there were no required employee contributions. For the years ended December 31, 2018 and 2017, plan expense, primarily employer contributions, was $341 million and $330 million, respectively.

(c) Multi-Employer Plans

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

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

Health Plans and Hospitals' participation in these plans for the year ended December 31, 2018 is outlined in the table below. The "EIN/PN" column provides the Employer 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 2018 and 2017 is for the plan's year-end in 2017 and 2016, 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 was 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 2018 and 2017 employer expense.

Pension fund	EIN-PN	Pension Protection Act zone status 2018	Pension Protection Act zone status 2017	FIP/RP status pending / implemented	(in millions) Health Plans and Hospitals' contributions December 31, 2018	(in millions) Health Plans and Hospitals' contributions December 31, 2017	Surcharge imposed	Health Plans and Hospitals' contributions to plan exceeded more than 5% of total contributions [1] 2017	Health Plans and Hospitals' contributions to plan exceeded more than 5% of total contributions [1] 2016	Expiration date of collective bargaining agreement
IUOE Stationary Engineers Local 39 Pension Fund	946118939 -001	Green	Green	N/A	$ 12	$ 11	No	Yes	Yes	9/17/2021
Southern California United Food and Commercial Workers Unions and Drug Employers Pension Fund	516029925 -001	Red	Red	Implemented	6	6	No	Yes	Yes	2/1/2020
Oregon Retail Employees Pension Trust[2]	936074377 -001	Red	Red	Implemented	3	3	No	Yes	Yes	9/30/2021-10/31/2021
Solano - Napa County Electrical Workers Pensions Trust (IBEW Local 180)[3]	946220673 -001	Green	Green	N/A	—	—	No	Yes	Yes	5/31/2019
Other[4]	Various	Red	Red	Implemented	10	9	Yes/No	No	No	6/30/2019-4/30/2021
Other	Various	Green	Green		16	15		No	No	7/31/2018-5/31/2022
Other	Various	Yellow	Yellow		4	4		No	No	6/30/2019-6/30/2020
Total expense					$ 51	$ 48				

(1) Forms 5500 information was available for all plan years ended in 2017. The majority of plans have a plan year end of December 31.

(2) Includes UFCW Local 555 Pharmacy Techs and Radiologists expiring September 30, 2021 and October 31, 2021, respectively.

(3) 2017 was the first year that KP reached the 5% contribution threshold for this union. Total 2017 pension contributions for the year were $81K. For year-to-date 2018 total pension contributions were $92K.

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

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

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

	2018	2017
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 5,926	$ 5,436
Benefit obligation acquired through acquisition	—	40
Service cost	195	156
Interest cost	209	206
Plan amendments	16	(36)
Benefits paid or provided	(162)	(151)
Net actuarial loss (gain)	(828)	275
Benefit obligation at end of year	$ 5,356	$ 5,926
Change in plan assets:		
Fair value of plan assets at beginning of year	4,483	3,095
Actual return on plan assets	(157)	388
Contributions	162	1,151
Benefits paid or provided	(162)	(151)
Fair value of plan assets at end of year	$ 4,326	$ 4,483
Funded status	$ (1,030)	$ (1,443)
Amounts recognized in the balance sheet consist of:		
Noncurrent assets	$ —	$ —
Current liabilities	(4)	(4)
Pension and other retirement liabilities	(1,026)	(1,439)
	$ (1,030)	$ (1,443)
Amounts recognized in net worth:		
Net actuarial loss	$ 1,710	$ 2,184
Prior service credit	(1,440)	(1,889)
	$ 270	$ 295

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

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

	2018	2017
Service cost	$ 195	$ 156
Interest cost	209	206
Expected return on plan assets	(303)	(189)
Amortization of net actuarial loss	105	93
Amortization of prior service credit	(433)	(433)
Postretirement benefits expense	(227)	(167)
Other changes in plan assets and benefit obligations recognized in net worth:		
Net actuarial loss (gain)	(369)	76
Prior service credit	16	(36)
Amortization of net actuarial loss	(105)	(93)
Amortization of prior service credit	433	433
Total recognized in net worth	(25)	380
Total recognized in net periodic benefit cost and net worth	$ (252)	$ 213

During 2019, $53 million and $(426) million in estimated net actuarial loss and prior service credit, respectively, will be amortized from net worth into postretirement benefits expense.

During the year ended December 31, 2018 both the employer contributions and benefits paid or provided were $162 million. During the year ended December 31, 2017 the employer contributions and benefits paid or provided were $1.2 billion and $151 million, respectively. During 2018 and 2017, there were no participant contributions from active employees.

Actuarial assumptions used were as follows:

	2018	2017
Discount rates used for calculating postretirement benefits expense from January 1 to December 31	3.35% - 3.80%	3.70% - 4.45%
Discount rates for calculating December 31 accumulated postretirement benefit obligation	4.00% - 4.50%	3.35% - 3.80%
Discount rate for calculating February 1 accumulated postretirement benefit obligation	N/A	3.70%
Expected long-term rate of return on plan assets for calculating benefits expense	7.00%	6.00%

The following were the assumed health care cost trend rates used to determine the December 31, 2018 and 2017 benefit obligation and postretirement benefits expense for the years ended December 31, 2018 and 2017:

	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 – 2017	5.25% / 5.25%	6.50% / 6.50%	4.00%	4.50%	5.25%	4.25%	5.25% / 5.25%
Initial trend rate – 2018	5.25% / 5.00%	6.25% / 6.25%	4.00%	4.50%	5.00%	4.50%	5.25% / 5.00%
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	n/a	2022	2018	2026 / 2022

A 1% increase in the health care medical trend rate would increase the benefit obligation by $527 million and the service cost plus interest by $35 million. A decrease of 1% in the health care medical trend rate would decrease the benefit obligation by $490 million and the service cost plus interest by $35 million.

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

2019	$	162
2020		175
2021		191
2022		208
2023		226
2024-2028		1,455

Explanation of Investment Strategies and Policies

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

Capital Market Assumption Methodology

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

At December 31, 2018, the estimated fair value of retirement benefit trust assets by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Total
Assets:			
Cash and cash equivalents	$ 1	$ 159	$ 160
Broker receivables	—	14	14
U.S. equity securities	1,408	—	1,408
Foreign equity securities	570	—	570
Debt securities issued by the U.S. government	—	1,024	1,024
Debt securities issued by U.S. states		11	11
Foreign government debt securities	—	3	3
U.S. corporate debt securities	—	185	185
Non-U.S. corporate debt securities	—	24	24
U.S. agency mortgage-backed securities	—	70	70
Non-U.S. agency mortgage-backed securities	—	20	20
Other	—	15	15
Total assets	1,979	1,525	3,504
Liabilities:			
Broker payables	—	65	65
Other liabilities	—	28	28
Total liabilities	—	93	93
Total fair value of retirement benefit trust assets	$ 1,979	$ 1,432	3,411
Investments measured at NAV:			
Alternative investments:			
Absolute return			425
Risk parity			490
Total retirement benefit trust assets			$ 4,326

At December 31, 2017, the estimated fair value of retirement benefit trust assets by level was as follows (in millions):

	Quoted prices in active markets for identical assets level 1	Significant other observable inputs level 2	Total
Assets:			
Cash and cash equivalents	$ —	$ 263	$ 263
Broker receivables	—	1	1
U.S. equity securities	1,523	—	1,523
Foreign equity securities	605	—	605
Other	—	5	5
Total assets	2,128	269	2,397
Liabilities:			
Broker payables	—	—	—
Total liabilities	—	—	—
Total fair value of retirement benefit trust assets	$ 2,128	$ 269	2,397
Investments measured at NAV:			
Alternative investments:			
Absolute return			401
Risk parity			1,685
Total retirement benefit trust assets			$ 4,483

The target asset allocation for calculating postretirement benefits expense were as follows:

	Target 2018	Target 2017
Equity securities	45%	—
Debt securities	30%	—
Alternative investments	25%	100%
Total	100%	100%

Absolute return and risk parity investments include redemption restrictions. Absolute return and risk parity investments require 10 to 90 day written notice of intent to withdraw and are often subject to the approval and capital requirements of the fund manager. At December 31, 2018, absolute return and risk parity investments of $219 million were subject to lock-up periods of up to 2 years.

(b) Multi-Employer Plans

Health Plans and Hospitals participates in multi-employer union-administered retiree medical health and welfare plans that provide benefits to some union employees. Benefits for retirees under these plans are negotiated as part of the collective bargaining process. For the years ended December 31, 2018 and 2017, Health Plans and Hospitals' employer expense for both current and retiree benefits was $90 million and $83 million, respectively.

(15) Physicians' Retirement Plan

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

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

		2018		2017
Change in projected benefit obligation:				
Physicians' retirement plan liability at January 1	$	8,165	$	6,751
Service cost		454		342
Interest cost		291		266
Net actuarial loss (gain)		(981)		982
Benefits paid		(189)		(176)
Physicians' retirement plan liability at December 31	$	7,740	$	8,165
Accumulated benefit obligation at end of year	$	5,996	$	6,325
Change in plan assets:				
Fair value of plan assets at the beginning of year	$	—	$	—
Company contributions		189		176
Benefits paid		(189)		(176)
Fair value of plan assets at end of year	$	—	$	—
Funded status	$	(7,740)	$	(8,165)
Amounts recognized in the balance sheet consist of:				
Noncurrent assets	$	—	$	—
Current liabilities		(219)		(199)
Physicians' retirement plan liability		(7,521)		(7,966)
	$	(7,740)	$	(8,165)
Amounts recognized in net worth:				
Net actuarial loss	$	1,552	$	2,650

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

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

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

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

	2018	2017
Service cost	$ 454	$ 342
Interest cost	291	266
Amortization of net actuarial loss	117	65
Total benefit expense	862	673
Expected return on assets – investment income included in interest expense and other income (expense) – net	(570)	(468)
Net benefit expense	292	205
Other changes in projected benefit obligations recognized in net worth:		
Net actuarial loss (gain)	(981)	982
Amortization of net actuarial loss	(117)	(65)
Total recognized in net worth	(1,098)	917
Total recognized in net periodic benefit cost and net worth	$ (806)	$ 1,122

During 2019, $50 million in estimated net actuarial loss will be amortized from net worth into net benefit expense.

Actuarial assumptions used were as follows:

	2018	2017
Discount rate at January 1 for calculating benefit expense	3.85%	4.55%
Discount rate for calculating December 31 PBO	4.60%	3.85%
Salary scale for calculating pension expense	4.40%	4.40%
Salary scale for calculating December 31 PBO	4.40%	4.40%
Expected long-term rate of return on designated investments for calculating benefit expense	7.00%	7.00%

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

2019	$ 219
2020	241
2021	265
2022	289
2023	312
2024–2028	1,887

(16) Commitments and Contingencies

(a) Lease and Purchase Commitments

Health Plans and Hospitals leases 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, 2018, minimum commitments under noncancelable leases extending beyond one year were as follows (in millions):

2019	$	386
2020		382
2021		317
2022		246
2023		202
Thereafter		545
Total	$	2,078

Minimum payments above have not been reduced by minimum sublease rentals of $3 million due in the future under noncancelable subleases.

For the years ended December 31, 2018 and 2017, total lease expense for all leases was $515 million and $490 million, respectively.

At December 31, 2018, minimum purchase commitments extending beyond one year were as follows (in millions):

2019	$	216
2020		205
2021		52
2022		42
2023		3
Thereafter		6
Total	$	524

During the years ended December 31, 2018 and 2017, Health Plans and Hospitals' total purchases under contracts with minimum purchase commitments were $660 million and $576 million, respectively.

(b) Surety Instruments and Standby Letters of Credit

In the normal course of business, Health Plans and Hospitals contracts to perform certain financial obligations that require a guarantee from a third party. This guarantee creates a contingent liability to the entity that provides that guarantee. At December 31, 2018 and 2017, Health Plans and Hospitals had entered into surety instruments and standby letters of credit that totaled $126 million and $128 million, respectively.

Health Plan, Inc. and Kaiser Foundation Hospitals also guarantee payment of workers' compensation liabilities of certain Medical Groups under self-insurance programs. The majority of such liabilities are recorded as other long-term liabilities of Health Plan, Inc., as payment is provided for under the applicable medical service agreements. In addition to amounts accrued, at December 31, 2018 and 2017, pursuant to such guarantees, Health Plan, Inc. and Hospitals are contingently liable for approximately $130 million and $140 million, respectively, of certain Medical Groups' self-insured workers' compensation liabilities.

(c) Regulatory

Health Plans is required to periodically file financial statements with regulatory agencies in accordance with statutory accounting and reporting practices. Health Plans must comply with the various states' minimum regulatory net worth requirements generally under the regulation of the California Department of Managed Health Care and various state departments of insurance. Such requirements are generally based on tangible net equity or risk-based capital, and for California are calculated on the basis of combined net worth of Health Plans and Hospitals. At December 31, 2018 and 2017, the regulatory net worth, so defined, exceeded the aggregate regulatory minimum requirements by approximately $29 billion and $26 billion, respectively.

Health Plans' regulated subsidiaries maintain investments in various states where they are licensed. At December 31, 2018 and 2017, $6 million and $7 million, respectively, in securities were held to satisfy various state regulatory requirements.

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

In the ordinary course of business operations, Health Plans and Hospitals is 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, U.S. 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.

(d) Litigation

Health Plans and Hospitals is 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 records 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 civil subpoenas, Health Plans and Hospitals has 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. These matters could result in False Claims Act litigation, in which an unfavorable outcome could have a material adverse effect. No significant reserves have been provided related to these matters.

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.

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

Independent Auditors' Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

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

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, the combined financial statements of Kaiser Foundation Health Plan, Inc. and Subsidiaries and Kaiser Foundation Hospitals and Subsidiaries (Health Plans and Hospitals or Company), which comprise the combined balance sheet as of December 31, 2018 and 2017, and the related combined statements of operations and net worth and cash flows for the year then ended, and the related notes to the combined financial statements, and have issued our report thereon dated February 14, 2019.

Internal Control Over Financial Reporting

In planning and performing our audit of the combined financial statements, we considered Health Plans and Hospitals' internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the combined financial statements, but not for the purpose of expressing an opinion on the effectiveness of Health Plans and Hospitals' internal control. Accordingly, we do not express an opinion on the effectiveness of Health Plans and Hospitals' internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weakness or significant deficiencies may exist that were not identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. We did identify a certain deficiency in internal control, described below that we consider to be a significant deficiency:

HealthPlan Services, Inc. (HPS) is a service provider that processes enrollment of health exchange membership and collects associated premiums for the Company. KPMG identified a deficiency in the review over the HPS Service Organization Control Report. HPS received a qualified opinion on their control report due to HPS not having evidence that terminated employee and contractor's access was removed or disabled. This deficiency resulted in a risk that data could be manipulated or errors or irregularities could occur as a result of terminated HPS employees or contractors inappropriately accessing HPS' systems.

KPMG

Compliance and Other Matters

As part of obtaining reasonable assurance about whether Health Plans and Hospitals' combined financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

The Company's Response to the Finding

Management concurs with the assessment that the control designed to identify significant risk in the Service Organization Control Report for HPS didn't operate effectively to recognize the impact of HPS's qualified opinion related to a systems access issue with terminated employees and contractors. Management is developing a comprehensive plan that includes working with HPS to monitor remediation of their control gap as well as further enhancing management's end to end controls at precision levels that mitigate the risk of material misstatement.

The Company's response to the finding identified in our audit described previously was not subjected to the auditing procedures applied in the audit of the combined financial statements and, accordingly, we express no opinion on the response.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Health Plans and Hospitals' internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Health Plans and Hospitals' internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

KPMG LLP

San Francisco, California
February 14, 2019

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

Federal Uniform Guidance Report

Year Ended December 31, 2018

(With Independent Auditors' Report Thereon)

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

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55 Second Street
San Francisco, CA 94105

Independent Auditors' Report on Compliance for the Major Federal Program; Report on Internal Control Over Compliance; and Report on Schedule of Expenditures of Federal Awards Required by the Uniform Guidance

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

Report on Compliance for the Major Federal Program

We have audited Kaiser Foundation Health Plan, Inc. and Subsidiaries' (Health Plan) and Kaiser Foundation Hospitals and Subsidiaries' (Hospital) compliance with the types of compliance requirements described in the *OMB Compliance Supplement* that could have a direct and material effect on Health Plans' and Hospitals' major federal program for the year ended December 31, 2018. Health Plans' and Hospitals' major federal program is identified in the summary of auditors' results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with federal statutes, regulations, and the terms and conditions of its federal awards applicable to its federal programs.

Auditors' Responsibility

Our responsibility is to express an opinion on compliance for the Health Plans' and Hospitals' major federal program based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance*). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about Health Plans' and Hospitals' compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for the major federal program. However, our audit does not provide a legal determination of Health Plans' and Hospitals' compliance.

Opinion on the Major Federal Program

In our opinion, Health Plans and Hospitals complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on its major federal program for the year ended December 31, 2018.

Report on Internal Control Over Compliance

Management of Health Plans and Hospitals is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered Health Plans' and Hospitals' internal control over compliance with the types of requirements that could have a direct and material effect on the major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for the major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of Health Plans' and Hospitals' internal control over compliance.

A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A material weakness in internal control over compliance is a deficiency, or a combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A significant deficiency in internal control over compliance is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

Report on Schedule of Expenditures of Federal Awards Required by the Uniform Guidance

We have audited the combined financial statements of Health Plans and Hospitals as of and for the year ended December 31, 2018, and have issued our report thereon dated February 14, 2019, which contained an unmodified opinion on those combined financial statements. Our audit was conducted for the purpose of forming an opinion on the combined financial statements as a whole. The accompanying schedule of expenditures of federal awards is presented for purposes of additional analysis as required by the Uniform Guidance and is not a required part of the combined financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the combined financial statements. The information has been subjected to the auditing procedures applied in the audit of the combined financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the combined financial statements or to the combined financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of expenditures of federal awards is fairly stated in all material respects in relation to the combined financial statements as a whole.

KPMG LLP

San Francisco, California
September 20, 2019

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

Schedule of Expenditures of Federal Awards

Year ended December 31, 2018

Federal grantor/pass-through grantor/program or cluster title	Federal CFDA number or pass-through entity identifying number	Total 2018 SEFA expenditures	Total 2018 expenditures to subrecipients
Research and Development Cluster:			
U.S. Department of Health and Human Services:			
Agency for Healthcare Research and Quality	93.226	$ 4,145,643	1,402,370
Agency for Healthcare Research and Quality	93.RD	3,028,108	888,043
Centers for Disease Control and Prevention	93.064	190,852	—
Centers for Disease Control and Prevention	93.073	171,405	46,896
Centers for Disease Control and Prevention	93.136	404,326	—
Centers for Disease Control and Prevention	93.185	937,088	87,347
Centers for Disease Control and Prevention	93.848	1,173,525	167,419
Centers for Disease Control and Prevention	93.RD	10,241,448	—
Food and Drug Administration	93.RD	205,864	152,358
National Cancer Institute	93.393	7,123,111	2,282,888
National Cancer Institute	93.394	1,551,356	568,839
National Cancer Institute	93.395	3,830,118	1,409,017
National Cancer Institute	93.396	3,086,059	917,946
National Cancer Institute	93.397	511,398	136,245
National Cancer Institute	93.398	754,738	—
National Cancer Institute	93.RD	540,651	—
National Center for Chronic Disease Prevention and Health Promotion	93.068	1,141,259	574,717
National Center for Chronic Disease Prevention and Health Promotion	93.945	332,947	—
National Center for Complementary and Integrative Health	93.213	299,622	34,870
National Eye Institute	93.867	612,516	78,772
National Heart, Lung, and Blood Institute	93.837	7,032,447	2,491,924
National Human Genome Research Institute	93.172	4,953,076	2,336,310
National Institute on Aging	93.866	8,983,772	2,690,334
National Institute on Alcohol Abuse and Alcoholism	93.273	1,326,239	193,651
National Institute of Allergy and Infectious Diseases	93.855	1,343,852	406,604
National Institute of Child Health and Human Development	93.865	2,233,515	1,121,274
National Institute of Dental and Craniofacial Research	93.121	402,812	56,669
National Institute of Diabetes and Digestive and Kidney Diseases	93.847	12,042,267	2,959,592
National Institute on Drug Abuse	93.279	6,653,621	3,641,908
National Institute on Drug Abuse	93.344	385,929	333,917
National Institute of Environmental Health Sciences	93.113	384,109	36,937
National Institute of General Medical Sciences	93.859	279,059	—
National Institute of Mental Health	93.242	7,448,788	3,993,647
National Institute on Minority Health and Health Disparities	93.307	667,940	177,733
National Institute of Neurological Disorders and Stroke	93.853	2,140,759	224,177
National Institutes of Health	93.310	6,996,370	1,704,137
National Library of Medicine	93.879	327,256	16,621
U.S. Department of Health and Human Services – subtotal		103,883,845	31,133,162
Pass-through awards from:			
Abt Associates Inc.	44753,TONo.49447	465,038	—
Abt Associates Inc.	GS00F252CA/200-2016-F-92356	8,964	—
Abt Associates Inc.	HHSA290201600006C	645,912	—
Abt Associates Inc.	HHSD20002013M53890B/200-2013-F-57544	5,000	—
Abt Associates Inc.	TO 44965	5,044	—
Albert Einstein College of Medicine	R01CA218429	163,169	—
Baylor College of Medicine	5601129715	118,121	—
Boston Children's Hospital	R01HG010004	35,173	—
Boston Children's Hospital	5U18HS025299-03	84,448	—
Brigham and Women's Hospital	UG3OD023268	315,022	—
Brigham and Women's Hospital	R01HL091528	211,467	—
Brigham and Women's Hospital	R01AI107721	136,387	—
California Pacific Medical Center	R01AT009081	38,158	—
Cedars-Sinai Medical Center	001235528 – R01HL117983	(13,674)	—
Cedars-Sinai Medical Center	5U01DK108314/Sub 0001355286	33,575	—
Children's Hospital Oakland Research Institute	12_8036_KAISER_01	460,045	—
Children's Hospital of Philadelphia	U10CA180886	207,790	—
Children's Hospital of Philadelphia	UG1CA189955	8,206	—
Children's Mercy Kansas City	1R21HD094106-01	12,012	—
City of Hope	R01NR015341	209,053	—
City of Hope	1R01CA202712	108,951	—
City of Hope	60223.2004190.669302	67,449	—
City of Hope	R01CA166219	36,596	—
City of Hope	R01CA184585	24,520	—
Claremont Graduate University	R01HD074416	26,583	—
Columbia University Medical Center	R01HL114924	76,050	—
Community Health Center, Inc.	100218-01	504	—
Community Health Center, Inc.	U30CS29049	2,916	—
Dana Farber Cancer Institute, Inc.	1R01CA172143	58	—
Dana Farber Cancer Institute, Inc.	R01CA218651	168,465	—
Denver Health & Hospital Authority	R24HS022	17,015	—
Denver Health & Hospital Authority	E4041-1R34DA039381	7,895	—
Drexel University	UG30D023342	95,324	—

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Duke University	203-7676	$ 85,007	—
Duke University	U24AT009676	102,781	—
Duke University	2035755	49,289	—
Duke University	R01DA040056	9,177	—
Duke University	U2COD023375	3,781	—
Duke University	HHSN2722013000171	40,133	—
Duke University	2038972	253,538	77,959
Emory University	R01AI125405	32,026	—
Emory University	1R01HD092595	102,175	—
Emory University	1R01HD092595-01	40,201	—
Emory University	T85300	173,095	—
Fred Hutchinson Cancer Research Center	0000891001	19,640	—
Fred Hutchinson Cancer Research Center	0000904149-215662 S7273	16,878	—
Fred Hutchinson Cancer Research Center	570229 / 3788077	1,837	—
Fred Hutchinson Cancer Research Center	5R01CA166646-05	4,388	—
Fred Hutchinson Cancer Research Center	5R01CA168338	13,244	—
Fred Hutchinson Cancer Research Center	5R01CA192402-03	5,186	—
Fred Hutchinson Cancer Research Center	5R01CA196337	3,317	—
Fred Hutchinson Cancer Research Center	5R03CA186215	(13,748)	—
Fred Hutchinson Cancer Research Center	5U01CA163304	13	—
Fred Hutchinson Cancer Research Center	R01CA168758	(1,720)	—
Fred Hutchinson Cancer Research Center	R01CA206279	253,281	—
Fred Hutchinson Cancer Research Center	R01HS0189829920110026	40,470	—
Fred Hutchinson Cancer Research Center	U01CA199338	13,148	—
Fred Hutchinson Cancer Research Center	U24CA221936	6,620	—
Fred Hutchinson Cancer Research Center	0000924224	40,121	—
Fred Hutchinson Cancer Research Center	1UG3CA218909-01	10,548	—
Fred Hutchinson Cancer Research Center	0000903336-215435 S7264	35,568	—
Fred Hutchinson Cancer Research Center	5R01AG048209-03	7,627	—
Fred Hutchinson Cancer Research Center	R01AG048209 / 0000876461	24,415	—
Geisinger Clinic	646018KPCO01	27,359	—
Geisinger Clinic	R01CA211723	176,983	—
George Washington University	7R01HL113550	10	—
George Washington University	5UM1AI069503	217,067	—
George Washington University	U01DK098246	1,428,107	—
Georgetown University	411120_GR411047-GHC	96,203	—
Georgetown University	GR412124 _GR411134-GHC	12,458	—
Georgetown University	R01CA190221	162,300	—
Georgetown University	R01CA207361	138,979	—
Georgetown University	U01CA183081	55,442	—
Georgetown University	U01CA199218	16,047	—
Georgia State University	R34AT009538	6,690	—
Georgia State University	SP00013079-03	2,500	—
Governing Council of the University of Toronto	R01MH102229	104,849	—
Group Health Research Institute	3UG1DA040314	77	—
Group Health Research Institute	5R01CA172073	18,756	—
Group Health Research Institute	5R01MH099666	7	—
Group Health Research Institute	5U19MH092201	58	—
Harvard Pilgrim Health Care, Inc.	5R01CA207373-02	17,919	—
Harvard Pilgrim Health Care, Inc.	AH000632	40,369	—
Harvard Pilgrim Health Care, Inc.	HHSF22301001T	23,465	—
Harvard Pilgrim Health Care, Inc.	HHSF22301002T	250,027	—
Harvard Pilgrim Health Care, Inc.	HHSF22301004T	1,841	—
Harvard Pilgrim Health Care, Inc.	HHSF22301006T	10,906	—
Harvard Pilgrim Health Care, Inc.	HHSF22301008T	2,060	—
Harvard Pilgrim Health Care, Inc.	HHSF22301009T	6,352	—
Harvard Pilgrim Health Care, Inc.	HHSF22301012T	171,427	—
Harvard Pilgrim Health Care, Inc.	HHSF22320091000009I	144,288	—
Harvard Pilgrim Health Care, Inc.	HHSF223200910006I	20,146	—
Harvard Pilgrim Health Care, Inc.	HHSF2232010000091	15,910	—
Harvard Pilgrim Health Care, Inc.	HHSF223201000009I	4,303	—
Harvard Pilgrim Health Care, Inc.	HHSF2232014000421	303,451	—
Harvard Pilgrim Health Care, Inc.	HHSF22320140030I	455,930	—
Harvard Pilgrim Health Care, Inc.	HHSF223201710132c	86,976	—
Harvard University	112518-5095861	21,257	—
Harvard University	5R01ES024332-02	5,499	—
HealthPartners Institute for Education and Research	R01HL124461	74,040	9,488
HealthPartners Institute for Education and Research	X1318600KPNCal	208,278	—
HealthPartners Institute for Education and Research	X1402500KPNCal	223,048	—
Henry Ford Health System	R01MH103539	49,734	—
Henry Ford Health System	U18PS005154	51,971	—
Henry Ford Health System	B11123GHC	38,073	—
Henry Ford Health System	B11159	112,053	—
Henry Ford Health System	B11159KPWASH	34,045	—
Henry Ford Health System	R01MH103539	190,168	27,269
Henry Ford Health System	U01MH114087	461,917	—
Icahn School of Medicine at Mount Sinai	R01CA166827	46,015	—
Icahn School of Medicine at Mount Sinai	R01CA210806	199,902	—
Icahn School of Medicine at Mount Sinai	0255-6614-4609	27,267	—
Icahn School of Medicine at Mount Sinai	5U01NS086625-04	19,238	—

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ID Genomics Inc	5R42AI116114-03	$ 9,573	—
ID Genomics Inc	5R42AI116114-04	9,483	—
ID Genomics Inc	IDG_GHRI_02 / IDG PO NO. 1049	55,814	—
Indiana University	1949523	112,146	—
Indiana University	R01MH103310	82,974	—
John Snow, Inc	HHSP233201500019I	7,531	—
Johns Hopkins University	R01ES023780 / 2002756959	2,593	—
Johns Hopkins University	R01ES025531	5,360	—
Johns Hopkins University	2002676448	60,619	—
Johns Hopkins University	2U01AI069918	70,572	—
Johns Hopkins University	U01 AI069918PO#2000352521	96,553	—
Johns Hopkins University	R01MH110437	77,773	—
Klein Buendel, Inc.	R01CA210259	59,316	—
Massachusetts General Hospital	R01HL132786	79,682	—
Massachusetts General Hospital	K24AR069760	29,814	—
Mayo Clinic	U01NS080168	75,048	—
Memorial Sloan Kettering Cancer Center	R01CA222090	12,561	—
Memorial Sloan Kettering Cancer Center	R37CA222793	222,616	—
Modulated Imaging, Inc.	2R44DK094625/PO10000516	41,274	—
Mount Sinai Hospital	0255-1801-4609	93,604	—
Northern California Institute for Research and Education	SEAL2078-07	2,500	—
Northern California Institute for Research and Education	UG3AT009765	4,092	—
Northern California Institute for Research and Education	1R56AG056417-01 REVISED	76,114	—
Northern California Institute for Research and Education	BAR2076-01	311,261	—
National Committee for Quality Assurance	HHSN316201200139W	13,661	—
National Committee for Quality Assurance	U18HS025296	14,338	—
National Jewish Health	20106901	6,725	—
National Jewish Health	1R01HL126125	573,569	—
New England Research Institutes, Inc.	U01HL107407	28,316	—
New York University School of Medicine	14-A0-00-003118-01 M150056007	65,876	—
New York University School of Medicine	5R01CA188353-03	28,356	—
New York University School of Medicine	R01HL128782	141,290	—
New York University School of Medicine	U01HL105907	3,412	—
New York University School of Medicine	U01HL117905	1,203	—
Northwestern University	R01HL131606	18,356	—
Northwestern University	60037126 KFRI	34,429	—
NRG Oncology Foundation, Inc.	5UG1CA189867	41,301	—
NRG Oncology Foundation, Inc.	NCORP04-Hahn	49,720	—
O.N. Diagnostics, LLC	OND-FUS2	9,825	—
Oregon Health & Science University	RO1DA034083	86,969	—
Oregon Health & Science University	CA32102	109	—
Oregon Health & Science University	1010835_KFRI	446,555	—
Oregon Health & Science University	K08HL140105	22,955	—
Oregon Health & Science University	R01HL136575	33,058	—
Oregon Health & Science University	R34HL115032 / 1002919_KFRI	7	—
Oregon Health & Science University	HHSF290201500009I	8,000	—
Palo Alto Veterans Institute for Research	FIN067960	43,328	—
Portland State University	R34MH111536	132,269	—
Public Health – Seattle & King County	1128 PREV – AM2	65,969	—
Public Health – Seattle & King County	5NU51PS004601-04	29,237	—
Public Health Foundation Enterprises, Inc.	NU50CK000482	231,301	—
Public Health Institute	1R01MH103539	(140)	—
Public Health Institute	U01MH114087	17,708	—
RAND Corporation	0801-80011-9922 CS113646	67,833	—
RAND Corporation	HHSN27120150064C	(4,091)	—
REBIScan	1R44EY025926	223,142	—
Regents of the University of Michigan	1UL1TR002240-01	12,602	—
Regents of the University of Michigan	5000016388	8,417	—
Regents of the University of Michigan	5R01HD079467	50,952	—
Regents of the University of Michigan	3004253190	226	—
Regents of the University of Michigan	5K08AG048321-04	1,461	—
Research Triangle Institute	1-312-0214368-65010L	3,314	—
Research Triangle Institute	R01DA034627	6,208	—
Research Triangle Institute	HHSA2902015000011i,TaskOrderNo.HHSA29032008t	10,533	—
Saint Louis University	21AG055604	102,419	—
San Diego State University Research Foundation	R01MH100260	53,664	—
Seattle Children's Hospital	11361SUB	5,046	—
Seattle Children's Hospital	5R21HD083770-02	15,388	—
Seattle Children's Hospital	11558SUB	6,280	—
Seattle Children's Hospital	U18DP006136	5,155	—
Sequoia Foundation for California	R01HD079533 / 9098 KFRI FY15-16	66,412	—
Southcentral Foundation	PSC-2013-090	17,443	—
Southcentral Foundation	U261IHS0079-01-00	8,827	—
Stanford University	R01CA067850	31,773	—
Stanford University	60851215-114970	46,641	—
Stanford University	1RF1AG053959-01	7,575	—
Stanford University	61345381-124531	6,853	—
Stanford University	RF1AG053959	10,580	—

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State of Colorado	D89MC2824/X10MC29463	$ 40,712	—
The Emmes Corporation	HHSN263201700001C	7,757	—
Trustees of Boston University	R01HL139751	3,864	—
Tufts Medical Center	U01DK098245	540,448	—
University of Alabama	U19DE022516	943,054	99,893
University of California, Davis	R01ES025574 / 201500641-03	7,384	—
University of California, Davis	201603696	263,047	—
University of California, Davis	P01CA154292	881,352	—
University of California, Davis	R01MH106518 / 201502924-01	23,289	—
University of California, Davis	U01 AG12554K931944	421,740	16,942
University of California, Irvine	U01DK102163	152,965	—
University of California, Los Angeles	1561 G UA211	167,003	—
University of California, Los Angeles	2000 G UD858	558,509	—
University of California, Los Angeles	2000GQE426	226,020	—
University of California, Los Angeles	R01HD091136	8,312	—
University of California, Los Angeles	R01MH112147	795,338	—
University of California, San Diego	2UG1HD054214	102,087	—
University of California, San Diego	U01HD041249	369,135	—
University of California, San Francisco	U01AI021997	174,664	—
University of California, San Francisco	R01DA043139	612,378	—
University of California, San Francisco	R21DA035645	175,727	—
University of California, San Francisco	KL2TR001870	26,778	—
University of California, San Francisco	5R01CA185687-03	45,578	—
University of California, San Francisco	5R01CA185687-04	82,060	—
University of California, San Francisco	8668SC	30,939	—
University of California, San Francisco	8674sc	418,031	—
University of California, San Francisco	R01 ES016443	7,501	—
University of California, San Francisco	R01CA1850588352sc	99,558	—
University of California, San Francisco	R01CA185687	271,037	—
University of California, San Francisco	R01CA201358	289,592	—
University of California, San Francisco	R01CA204070	146,210	—
University of California, San Francisco	R01CA1749298147sc	7,456	—
University of California, San Francisco	8292sc	23,726	—
University of California, San Francisco	R01NS099268	162,487	—
University of California, San Francisco	U10NS0864948122sc	21,467	—
University of California, San Francisco	R01GM117163 / 9063sc	208,389	—
University of California, San Francisco	U24GM115370 / 8926sc	31,024	—
University of California, San Francisco	K12HD052163	200,392	—
University of California, San Francisco	R01LM012355	160,539	—
University of California, San Francisco	HHSN268201100005I TO 3	27,126	—
University of California, San Francisco	HHSN268201100009I TO 2	51,289	—
University of California, San Francisco	HHSN268201100009I TO 3	19,694	—
University of California, San Francisco	HHSN275201300006I/HHSN275000018046sc	2,353	—
University of California, San Francisco	10291SC	524,487	—
University of California, San Francisco	R01AG057508-01	126,719	—
University of California, San Francisco	8523c	63,239	—
University of California, San Francisco	8958sc	43,386	—
University of California, San Francisco	K12DK111028	11,181	—
University of California, San Francisco	K23 DK1004687879sc	56,521	—
University of California, San Francisco	K24DK092291	30,933	—
University of California, San Francisco	R01DK0982338286sc	48,769	—
University of California, San Francisco	R01DK101507 8134sc	266,345	—
University of California, San Francisco	R01DK114014	12,326	—
University of California, San Francisco	U01DK108809	24,417	—
University of Chicago	R01MD013420	8,701	—
University of Cincinnati	UL1TR001425	87,421	—
University of Cincinnati	R01CA175346	42,173	—
University of Colorado Denver	R01DA031816	9	—
University of Colorado Denver	R34DA035952	(3,430)	—
University of Colorado Denver	1UL1TR002535	69,578	—
University of Colorado Denver	R01NR016467	21,892	—
University of Colorado Denver	1R01HL133343	357,745	—
University of Colorado Denver	1R01HD079457	257,645	—
University of Colorado Denver	1K12HL137862	374	—
University of Colorado Denver	R34MH110478	123,632	16,124
University of Colorado Denver	1UC4DK101108	9,776	—
University of Colorado Denver	5 U01 DK098246	41	—
University of Colorado Denver	5P30DK092923	41,294	—
University of Colorado Denver	5R18DK114757	713	—
University of Colorado Denver	5UA6MC31101-02	10,379	—
University of Hawaii at Manoa	5U01CA164973-07	48,436	—
University of Illinois at Chicago	DK072231-06A1	10,283	—
University of Iowa	R01FD005993	62,210	—
University of Massachusetts	R24AG045050	86,957	—
University of Massachusetts	R33AG057806	34,189	—
University of Massachusetts	WA00238442/RFS2015089	533	—
University of Nevada, Reno	R01AI122266 / UNR-16-46	400,288	—
University of North Carolina at Chapel Hill	1R01CA204258/Sub 510218	163,794	—
University of North Carolina at Chapel Hill	CA2042258	137,664	—
University of North Carolina at Chapel Hill	550KR141622	2,931	—

(Continued)

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University of North Carolina at Chapel Hill	U41HG009650	$ 586,130	—
University of North Carolina at Chapel Hill	5034479	5,368	—
University of Pennsylvania	R01CA213645	229,204	—
University of Pennsylvania	574952	137,827	—
University of Pennsylvania	R01HL136719	369,258	—
University of Pennsylvania	570229 / 3788077	52,141	—
University of Pennsylvania	565335	6,727	—
University of Pennsylvania	BPO17969	171,330	—
University of Pennsylvania	R01AG049815	9,282	—
University of Pennsylvania	R21AG058056	18,930	—
University of Pennsylvania	RO1AG20048	554,703	—
University of Pennsylvania	SC8599-BPO17819	103,805	—
University of Pittsburgh	0057616 (130185-1)	50,187	—
University of Pittsburgh	U01DE027452	186,620	—
University of Southern California	1R01CA206019-01	76,756	—
University of Southern California	1R01DK105517-01	194,689	—
University of Southern California	U01DK094430	279,774	—
University of Texas	GMO 180103	6,394	—
University of Texas	5U01CA200468/Sub 3001071850	331,324	—
University of Texas Southwestern Medical Center	R01CA212008-01A1	4,708	—
University of Texas Southwestern Medical Center	UM1CA221940	323,237	—
University of Washington	R01ES026187	56,285	—
University of Washington	R01ES027696	115,281	—
University of Washington	SC9375-BPO25311	18,263	—
University of Washington	SC9375-BPO28689	24,057	—
University of Washington	SC8001BPO17752	5,241	—
University of Washington	U48DP005013	10,611	—
University of Washington	UWSC8766BPO18591	27,744	—
University of Washington	6NU17CE002734-02-01	1,657	—
University of Washington	U01CE002967	42,730	—
University of Washington	UWSC10288 BPO 29354	27,987	—
University of Washington	5T90AT008544-03	19,084	—
University of Washington	UG3AT009838	203,235	—
University of Washington	UWSC8824_BPO15960	60,176	—
University of Washington	BPO 17262	4,704	—
University of Washington	BPO 27796	3,625	—
University of Washington	BPO16878	1,426	—
University of Washington	BPO29770	11,078	—
University of Washington	K12HS022982	11,887	—
University of Washington	R25HS023207	1,975	—
University of Washington	R01DA044970	92,708	—
University of Washington	UH3AR066795	10,316	—
University of Washington	UWSC7407-BPO11966	37,170	—
University of Washington	UL1TR002319	22,339	—
University of Washington	UWSC9813 BPO #23840	41,083	—
University of Washington	1R01CA207375	48,225	—
University of Washington	5R01CA168598-05	76,652	—
University of Washington	BPO14729	112,429	—
University of Washington	R01CA207375	60,088	—
University of Washington	UWSC10578 / 32625	4,089	—
University of Washington	UWSC9650	32,733	—
University of Washington	UWSC9668_BPO21745	201,792	—
University of Washington	UWSC10604 / BPO33117	25,480	—
University of Washington	5R01AI106007-05	19,104	—
University of Washington	UWSC7589 BPO1669	9,600	—
University of Washington	U48DP005013	200,065	—
University of Washington	UH3AR066795757764	50,576	—
University of Washington	3R01AG053221-02S1	27,220	—
University of Washington	5P50AG005136-34	36,151	—
University of Washington	5R01AG053221-02	64,676	—
University of Washington	R01AG056326	51,366	—
University of Washington	R21AG058056	74,305	—
University of Washington	UWSC9345BPO17969	68,537	—
University of Washington	5P30DK017047-42	5,481	—
University of Washington	BPO 11938 UWSC8809	8,691	—
University of Washington	R01DK076608	14,935	—
University of Washington	R01DK103612 / UWSC8595	10,932	—
University of Washington	R01DK104764	30,821	—
University of Washington	R01DK107931	30,514	—
University of Washington	SC9851-BPO24520	20,429	—

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Wake Forest University Health Sciences	WFUHS 114580	$ 410,916	—
Washington State Healthcare Authority	1G1CMS331406-01-00	63,812	—
Washington State Healthcare Authority	K1451-1	207,353	—
Weill Medical College of Cornell University	1U01 FD005478	67,122	—
Yale University	1R01CA155578-01 / RX 4442-025	36,525	—
Vanderbilt University Medical Center	R01AG059716	2,047	—
Pass-through programs – subtotal		34,059,551	247,675
Total U.S. Department of Health and Human Services		137,943,396	31,380,837
National Science Foundation:			
Social, Behavioral, and Economic Sciences	47.075	52,598	—
National Science Foundation – Subtotal		52,598	—
Pass-through funds from:			
Columbia University in the City of New York	GG009335	20,399	—
National Jewish Health	1743587	156,668	—
Pass-through Programs – subtotal		177,067	—
Total National Science Foundation		229,665	—
U.S. Department of Defense:			
Military Medical Research and Development	12.420	116,322	83,939
U.S. Department of Defense – subtotal		116,322	83,939
Pass-through funds from:			
Icahn School of Medicine at Mount Sinai	W81XWH-17-1-0330	71,159	—
University of California, San Francisco	W911NF14-2-0043 / 8916sc	24,178	—
Pass-through Programs – subtotal		95,337	—
Total U.S. Department of Defense		211,659	83,939
U.S. Department of Agriculture			
Pass-through funds from:			
University of Illinois	16-DG-11132544-036	49,708	—
Pass-through Programs – subtotal		49,708	—
Total U.S. Department of Agriculture		49,708	—
Department of Veteran's Affairs:			
Veteran's Administration Health Services Research and Development	64.RD	3,183	—
Department of Veterans Affairs – subtotal		3,183	—
Total Department of Veterans Affairs		3,183	—
Department of Education			
Pass-through funds from:			
Oregon Health & Science University	R34A150149	35,014	—
Pass-through Programs – subtotal		35,014	—
Total Department of Education		35,014	—
Total Research and Development Cluster		138,472,625	31,464,776
Non-Research and Development:			
U.S. Department of Agriculture			
Special Supplemental Nutrition Program for Women, Infants and Children	10.557	38,155	—
U.S. Department of Agriculture – subtotal		38,155	—
Total U.S. Department of Agriculture		38,155	—
U.S. Department of Health and Human Services:			
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	93.074	289,586	—
National Bioterrorism Hospital Preparedness Program	93.889	290,409	—
U.S. Department of Health and Human Services – subtotal		579,995	—
Pass-through funds from:			
California Department of Public Health			
Hospital Preparedness Program (HPP) Ebola Preparedness and Response Activities	93.817	248,720	—
Harvard Pilgrim Health Care, Inc.	HHSF223200910006I	153,542	—
Harvard Pilgrim Health Care, Inc.	HHSF22320140030I	440,018	—
Pass-through programs – subtotal		842,280	—
Total U.S. Department of Health and Human Services		1,422,275	—
Total Non Research and Development		1,460,430	—
Grand Total		$ 139,933,055	31,464,776

See accompanying independent auditors' report.

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

Notes to Schedule of Expenditures of Federal Awards

Year ended December 31, 2018

(1) Basis of Presentation

The accompanying Schedule of Expenditures of Federal Awards (the Schedule) includes the federal grant activity of Kaiser Foundation Health Plan, Inc. and Subsidiaries (Health Plans) and Kaiser Foundation Hospitals and Subsidiaries (Hospitals) under programs of the federal government for the year ended December 31, 2018. Expenditures reported on the Schedule are reported on the accrual basis of accounting. The information in this schedule is presented in accordance with the requirements of Title 2 U.S. Code of Regulations (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*.

Research and development programs are presented by federal agency and major subdivision within the federal agency. Pass-through programs are presented by pass-through entity name and identifying number. Catalog of Federal Domestic Assistance (CFDA) numbers are presented for those programs for which such numbers are available.

(2) Federal Loan and Loan Guarantee Programs

Health Plans and Hospitals did not expend any federal funds to support loan programs or loan guarantee programs. Health Plans and Hospitals do not have federal loan balances outstanding as of December 31, 2018.

(3) Indirect Cost Rate

Health Plans and Hospitals have negotiated Facilities & Administration rates from the Division of Cost Allocation. Health Plans and Hospitals have elected not to use the 10% de minimis cost rate.

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

Schedule of Findings and Questioned Costs

Year ended December 31, 2018

(1) Summary of Auditors' Results

1. Type of report issued on whether the combined financial statements were prepared in accordance with generally accepted accounting principles: **Unmodified**

2. Internal control deficiencies over financial reporting disclosed by the audit of the combined financial statements:

   - Material weaknesses: **No**
   - Significant deficiencies: **Yes**

3. Noncompliance material to the combined financial statements: **No**

4. Internal control deficiencies over major programs disclosed by the audit:

   - Material weaknesses: **No**
   - Significant deficiencies: **None reported**

5. Type of report issued on compliance for major programs: **Unmodified**

6. Audit findings that are required to be reported in accordance with 2 CFR 200.516(a): **No**

7. Major programs:

Program	CFDA
Research and Development	**Cluster**

8. Dollar threshold used to distinguish between Type A and B programs: **$3,000,000**

9. Auditee qualified as a low-risk auditee: **Yes**

(2) Finding Relating to the Combined Financial Statements Reported in Accordance with *Government Auditing Standards*

Finding 2018-001: Service Vendor Control Review

The Company must establish and maintain effective internal control over financial reporting, and of compliance with provisions of laws, regulations, contracts, or grant agreements.

HealthPlan Services, Inc. (HPS) is a service provider that processes enrollment of health exchange membership and collects associated premiums for Health Plans and Hospitals. HPS received a qualified opinion on their control due to HPS not having evidence that terminated employee and contractor's access was removed or disabled.

Health Plans' and Hospitals' policies and procedures did not operate effectively to recognize the impact of HPS' qualified opinion related to a systems access issue with terminated employees and contractors.

This deficiency resulted in a risk that data could be manipulated or errors or irregularities could occur as a result of terminated HPS employees or contractors inappropriately accessing HPS' systems.

Management Response

Management concurs with the assessment that the control designed to identify significant risk in the Service Organization Control Report for HPS didn't operate effectively to recognize the impact of HPS' qualified opinion related to a systems access issue with terminated employees and contractors. Management is developing a comprehensive plan that includes working with HPS to monitor remediation of their control gap as well as further enhancing management's end to end controls at precision levels that mitigate risk of material misstatement.

(3) Findings and Questioned Costs Relating to Federal Awards

None Reported.

Kaiser Foundation Health Plan, Inc. and Subsidiaries and
Kaiser Foundation Hospitals and Subsidiaries
Uniform Guidance Single Audit
Calendar Year 2018

Corrective Action Plan

Reference	Finding	Status	Contact Person	Anticipated Completion Date
2018-001	**Service Vendor Control Review** HealthPlan Services, Inc. (HPS) is a service provider that processes enrollment of health exchange membership and collects associated premiums for the Health Plan. KPMG identified a deficiency in the review over the HPS Service Organization Control Report. HPS received a qualified opinion on their control report due to HPS not having evidence that terminated employee and contractor's access was removed or disabled. This deficiency resulted in a risk that data could be manipulated, or errors or irregularities could occur as a result of terminated HPS employees or contactors inappropriately accessing HPS' systems.	**In Progress** Management concurs with the assessment that the control designed to identify significant risk in the Service Organization Control Report for HPS didn't operate effectively to recognize the impact of HPS' qualified opinion related to a systems access issue with terminated employees and contractors. Management is developing a comprehensive plan that includes working with HPS to monitor remediation of their control gap as well as further enhancing management's end to end controls at precision levels that mitigate risk of material misstatement.	Daniel E McDermott	March 2020

Kaiser Foundation Health Plan, Inc. and Subsidiaries and
Kaiser Foundation Hospitals and Subsidiaries
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Summary Schedule of Prior Audit Findings

Reference	Finding	Status	Contact Person
2017-01	**Allocation of Program Costs** During 2017, the computation of the allocated costs performed by Program Offices was not consistent with their approved methodology, resulting in errors which understated or overstated the amount charged to the regional health plans. The design of the review control at the Company was not precise enough to identify significant inconsistencies between Program Offices' approved methodology and the entries recorded in the Company's regional health plans' financial statements.	**Fully Corrected on November 5, 2018**	Tiffany M. Dare